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ABSTRACT

This document consists of Part 2 of a book of readings on at-risk youth designed to provide information and strategies for counselors, teachers, parents, administrators, social workers, and others who work with youth at risk. Part 2 contains five readings on causal factors related to at-risk behaviors. "The Harmful Effects of Dysfunctional Family Dynamics" (Artis Palmo & Linda Palmo) presents information on the effect of family dynamics on the development of at-risk behaviors in youth, therapeutic treatment modalities for dysfunctional families, the use of referral and consultation with families of at-risk children, and the process of assessment with families of at-risk youth. "Bodily Assault: Physical and Sexual Abuse" (Robert Rencken) presents the incidence and effects of physical and sexual abuse, the dynamics of the youthful offender, and strategies for intervention. "'Who Cares What I Think?': Problems of Low Self-Esteem" (Sandra Meggert) examines low self-esteem as a primary cause of at-risk behavior and provides a framework and strategies to aid in creating positive levels of self-esteem. "When Life Seems Darkest: Adolescent Depression" (J. Jeffries McWhirter & Benedict McWhirter) addresses the symptoms, causes, and treatment of adolescent depression. "The Society We Live In: Stress and Coping" (Art Terry & Sylvia Milliken) provides information related to the stress response mechanism; explores the daily stressors of youth as these relate to biological, developmental, and individual relationships; and provides application and intervention techniques as well as recommendations and suggestions for program implementation. (NB)

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Part II

EXAMINING THE CAUSES

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Chapter 3

THE HARMFUL EFFECTS OF DYSFUNCTIONAL FAMILY DYNAMICS

Artis J. Palmo and Linda A. Palmo

As presented in the first chapter, the problem of youth at risk is not new; but rather, the use of a new phrase to describe an old problem. The Pennsylvania Department of Education (1987) described the at-risk student as one ". . . who runs the risk of not acquiring the knowledge, skills, and attitudes neded to become successful adults . . ." (p. 1). This description is profound when considering the at-risk youth from a family perspective. If parents have been unable to acquire the "knowledge, skills, and attitudes needed to become successful adults," how destined are their children to be youth at risk? If youth are at risk, are parents also at risk? Can entire families be at risk?

The basic premise for this chapter is that the at-risk behaviors exhibited by the youth are a direct result of dysfunctional family dynamics. As you will note from the case studies presented throughout the chapter, frequently the at-risk youth is a representation of the chaos, disruption, and pain in the family as a whole. Parents, in reaction to the problems presented by the at-risk youth, may attempt to find simple solutions to complex questions, therefore avoiding the possibility of exploring or admitting their own dysfunctional family dynamics to themselves or any helping professional who may be involved with the at-risk youth.

Considering the relationship between family dynamics and the problem of at-risk youth, the goals of the chapter are to: (1) provide an understanding of the effects of family dynamics on the development of at-risk behaviors in youth; (2) discuss the therapeutic treatment of dysfunctional families and individual family members; (3) understand the

effective use of referral and consultation with dysfunctional families; and (4) understand the process of assessment with families of at-risk children. By studying the information and discussions presented in these four areas (development, treatment, referral, and assessment), the reader should be able to provide more effective and comprehensive services to those youth identified as being at risk as well as their families.

Developmental Issues

Recent literature (Abbott, 1978; Anderson & Limoncelli, 1982; Kunisawa, 1988; Stevens & Pihl, 1982a, 1982b; Zarb, 1981, 1984) describes a multitude of characteristics, attributes, and reasons for at-risk status. Gadwa and Griggs (1985) categorize these into four areas when discussing the development of at-risk behaviors in youth: family, personal characteristics, socioeconomic factors, and school behavior. Although the Gadwa and Griggs study referred primarily to at-risk status of potential high school dropouts, their categorization can be generalized to all at-risk youth, regardless of the primary presenting problem. Two implications pervade these studies of at-risk youth. First, family dynamics and patterns of interaction are a key reason for the development of at-risk status. Second, the problems and characteristics of at-risk youth are multidimensional and seldom come from only one source.

The interaction of family dynamics and family background with a multitude of other factors provides the medium for the at-risk youth's inappropriate or maladjustive behaviors. The problematic dynamics in the family of the at-risk youth are multidimensional and can range from mild to moderate in severity. But, it is not unusual for multiple problems to exist in the home (Anderson & Limoncelli, 1982). The at-risk behaviors of youth are demonstrated in all types of families: rich and poor, blue collar and white collar, two-parent and single-parent, educated and uneducated. No family is immune to the potential for dysfunctional family dynamics.

Family Influence on Individual Problems

Following the identification of the at-risk youth by the school, community officials, or parents, much attention is often given directly to the youth without commensurate attention to the entire family. Without the involvement of the family in the assessment process it is impossible to understand the true functional level of the at-risk youth. How the youth begins to feel "out of place" within the family (Dinkmeyer, Dinkmeyer, & Sperry, 1987) will certainly influence how the youth feels out

of place in the world at large. The problems expressed by the at-risk youth are a direct result of difficulties experienced either overtly or covertly by the family unit. Therefore, an accurate assessment and development of a treatment plan for an at-risk youth must be accompanied by a thorough assessment of the family and an involvement of the family in the treatment.

The at-risk youth is a representative of the family and symbolizes the severity of the difficulties within the family unit. The greater the difficulties demonstrated by the youth, the larger the number of issues that need attention within the family. Although there are examples of at-risk youth with pathologies that do not provide an honest picture of the family's difficulties, in most instances the youth's behaviors are an accurate barometer of the family's stability. A brief case example will demonstrate the above presentation.

> Justin, a 14-year-old freshman, was referred for counseling by the school following a report that he was suicidal. Two of Justin's friends found a letter describing how he planned to shoot himself. Justin, along with his mother and father, came for counseling. It was apparent during the initial session that Justin did not want to be in counseling. He was rude, obnoxious, and embarrassing to his parents. Mother was tearful, while father remained stoic. Both parents were obviously shaken by Justin's recent behaviors. The counselor attempted to assist the family in understanding the relationship between the issues Justin expressed and the problems the family faced. Both mother and father were willing to accept their responsibility for the apparent problems, but Justin refused. Justin claimed that all was well with him *now*, and he no longer needed help and was not going to hurt himself. He "won" because the family did not return for counseling or force Justin to return.
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> In conceptualizing the issues Justin and his family faced, it is possible to understand how the parents "lost" control of their son. Justin was an only child of two very ambitious parents, both of whom worked long hours to provide for the family. On the other hand, his parents perceived Justin as physically lazy, irresponsible, and a failure in school. The parents, however, never pushed Justin to do schoolwork or take responsibility for chores around the house. Because Justin was so resistant, he was able to do as he pleased because the parents no longer wanted to fight with him. He made a plea for their attention with the suicide letter, and once he got the

attention he desired from the parents, he returned to his previous behaviors. He was now capable of "blackmailing" his parents more effectively than ever before.

The purpose of this brief case presentation is to demonstrate the relationship between the behavior of the at-risk youth and the difficulties the individual family members face. The parents ignored their own needs as a couple to provide for Justin. He was spoiled and irresponsible, and generally ungrateful for what they had been able to provide, *but* quite angry about what his parents were *not* providing. Therefore, this parentified child (Palmo & Palmo, 1988) used the most powerful weapon in his arsenal, a suicide threat, to gain the attention he desired. Justin used the suicide threat as a coping style shortly after the suicide of one of his classmates.

Once Justin received the attention he desired, he was somewhat embarrassed. School officials were involved, his friends were afraid to be with him, the extended family was concerned, and all-in-all he had created a situation where he was never alone. Someone was always watching him. So from a feeling of being ignored by his family and friends to a 24-hour watch of his activities, Justin had come full circle. Now Justin wished for everything and everyone to return to normal.

Justin did not understand how he represented the dynamics of his family. He displayed the insecurity of a father who worked 16 to 18 hours at two jobs, always frightened that he might be considered a failure by his own father. He displayed the loneliness of a mother who desired more from a marriage than she felt she was receiving. Finally, Justin displayed the anger of a child who does not feel loved and therefore cannot love. Assessing Justin's problems without an understanding of his family dynamics would lead to the possibility of an inappropriate treatment plan. The at-risk youth is a representative of the family and displays the discord the family as a whole feels.

Family Dynamics and At-Risk Behaviors

Once the youth demonstrates at-risk behaviors, the family dynamics play a significant role in whether or not the at-risk behaviors will escalate or decrease. If the dysfunctional aspects of the family dynamics are not identified, discussed, and changed, the behaviors of the at-risk youth will continue to escalate. It is common knowledge that conflicts between the parents, whether overt or covert, have a significant impact on the behavior of the children. However, for the at-risk youth, the parental conflict has a compounding effect. Whereas one child in the family may choose to ignore mother and father's problems by spending more time

with friends and another by putting excessive energy into school, the at-risk youth finds it difficult to resist potential problem areas. A brief case example will help.

> Jim, a 17-year-old junior, was referred for help because of difficulties at school. He was failing several classes, had been dismissed from classes for misbehavior, and had cut school. Jim was also the star of the high school football team. School officials suspected Jim was drinking heavily during the school year. The family came for counseling, except for the oldest daughter who was attending college. Father was a professional, and mother stayed home to raise the children. Besides the sister, Jim has a brother of 15.
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> At the initial sessions, the parents informed the counselor that Jim had had difficulties for the past 2 years, but they had never sought help. The parents suspected drinking, but felt it was at minimal levels. They also reported that Jim had difficulty following rules at home and basically directed his own behaviors without much interference from either of the parents. Of the three children, Jim was by far the most difficult to raise. Jim's sister was successful at college and his brother was successful in school and was no problem at home.
>
> Counseling with Jim and the family over a period of several months proved fruitless. Regardless of the efforts of the counselor and the repeated efforts of the parents, Jim's behavior did not improve, but actually got worse. Finally, after several sessions with the parents, both individually and as a couple, it was determined that the marriage was in severe trouble. Father was having an affair, unbeknown to the mother and family. Mother was significantly overweight and suffering from severe physical problems. The marriage relationship was the core of the family problems. However, when confronted with their marital problems, both parents were unwilling to pursue in-depth marriage counseling to solve their differences. The result of this decision was predictable. Not only did the marriage get worse, but Jim also got worse. He completed his junior year and spent the summer causing difficulties for his parents.

The point this example makes is that the unresolved issues of the parents and family significantly affect the behavior of the at-risk youth. Although Jim's siblings seem to be successfully progressing through their development with relative ease, Jim is having severe difficulty keeping his life in order. As Jim continued through high school he drank more,

lost his driver's license for speeding and reckless driving, and was in jail for disturbing the peace. Jim became more and more of a danger to himself, his family, and his friends. During this time, the couple's relationship became more and more of a problem. Father's affair was discovered, although the full extent of the third party relationship was never fully disclosed. Divorce was considered, but little change was occurring at home in relation to parenting Jim.

The dynamics of the couple and family influence at-risk behavior, as demonstrated by the case of Jim. As the youth's at-risk behaviors increase and change, there is always a corresponding change in the dynamics of the family system. The at-risk youth is dependent upon the family dynamics for his or her support and encouragement; therefore, before the at-risk behaviors decrease, the dynamics of the personal interactions at home must change.

One final note must be made about Jim's family that reinforces the importance of understanding the impact of family dynamics on at-risk behavior. First, Jim's sister became very involved with her boyfriend from college and decided to transfer with him to a college 3,000 miles away from home. The move from the East Coast to the West Coast was the daughter's attempt to escape the situation at home with her parents and Jim's constant difficulties. However, the daughter is also at risk for pregnancy, early marriage, not finishing college, and so on. Second, the younger brother, who was very compliant during most of Jim's antics, was beginning to have problems himself. He was disobeying his parents more frequently and got himself into trouble with a neighbor for being a "peeping Tom."

All-in-all, the couple's difficulties, basically not known on an overt level by any of the children, caused the children to respond in their own way to receive the attention they desired. The family dynamics are an important determinant of the level of at-risk behavior exhibited by all of the children, not simply the youth identified as being at risk.

Development of Dysfunctional Family Dynamics

The development of dysfunctional family dynamics produces an at-risk youth who in turn exposes the dysfunctional family dynamics to the community. If the family's problems do not begin with the at-risk status of their son or daughter, as exemplified in the previous two case studies, how does a family become dysfunctional? The development occurs over a long period of time and is the result of numerous unresolved issues and problems.

The roots of dysfunctional family dynamics rest in the family of origin of the mother and father of the at-risk youth. The models they

were shown in their own families will have a driving influence on what they do or do not do with their own children. Unfortunately, many of the tactics used by parents in the past need to be adapted to today's world and today's youth. If the mother and father of the at-risk youth lack the self-awareness of how they have been shaped by their own families of origin, they will be unable to adapt their parenting style. The ability to develop successful family dynamics comes from a true understanding of the parents' own positive and negative development as children. The parents' ability to appropriately and accurately see themselves as members of their own family of origin will influence their children's ability to appropriately see themselves as members of the current family.

The development of dysfunctional family dynamics can also be rooted in an unhealthy marriage. The dynamics between parents are the precursor to the dynamics between parent and child. If a couple does not develop appropriate coping styles for resolving conflict and honest, open communication patterns in their marriage, they are at risk to parent at-risk youth. The ability to process marital conflict is essential to be able to process parent-child conflict issues. Often parents are more willing to address problems with their children than problems with the marriage. If parents are unwilling to address their own problems, their children will be unwilling to address their inappropriate behaviors.

Dysfunctional family dynamics can also occur when roles and responsibilities are not effectively defined in a family. At-risk youth have one common characteristic—regardless of the identified problem behavior, they all violate the established rules of the home, school, or community. The violation of standards and structure begins early in life and early in the development of family dynamics. If the parents do not agree on parenting responsibilities, then discipline, rules, and responsibilities will be poorly defined in the early development of the children. Because of the parental conflict, the child becomes parentified early in life. The child is often given major choices early in life and asked to direct his or her life appropriately. Without a sense of structure, the child seldom understands what "appropriate" means. Ultimately, the at-risk youth may split the parental conflict even further through his or her acting-out behaviors.

One note of importance when examining the development of dysfunctional family dynamics is the issue of stepfamilies. Frequently, we treat at-risk youth who are members of a new, restructured family unit. It seems, at least on the surface, that the at-risk behaviors are a result of the new family structure; however, further exploration of the at-risk youth's background will typically show that the problems were exhibited prior to parental divorce and remarriage. The losses that occur at the time of divorce and the changes necessitated by a restructured family

frequently provide the youth the impetus to exhibit critical at-risk behaviors.

In summary, the development of dysfunctional family dynamics provides fertile ground for the development of at-risk youth. At-risk youth exacerbate dysfunctional family dynamics. The assessment of family dynamics is not simply a black-or-white, good-or-bad, appropriate-or-inappropriate evaluation. There is a continuum of functional to dysfunctional family dynamics that may be evaluated at different levels of achievement depending on the time, the place, and the stage of development of the family members. When a family member is identified as an at-risk youth, it is credible to assume that the family is experiencing and will continue to experience increased dysfunctional relations among and between family members. It is highly significant to note that "fixing" the at-risk youth will not typically "fix" the dysfunctional family dynamics. Also, just as the problems develop over a long period of time, it will take a long period of time to solve the problems.

Levels of Dysfunction in the Family

When assessing the level of dysfunction in the family and the level of risk the youth exhibits, it is possible to classify families as either severely or moderately dysfunctional. The extent and type of treatment to be used with the family depends on the severity of the dysfunction in the family. Severely dysfunctional families usually are identified easily whereas many moderately dysfunctional families become expert at covering family difficulties. The following discussion will provide some distinctions between the two groupings.

Severely Dysfunctional Families

In the severely dysfunctional family, the at-risk youth is predictable because of the severe dysfunction of one or more adults in the family. The adult(s) in the family may have been dysfunctional in the past or may presently exhibit many at-risk behaviors. For example, the adult(s) may have a poor work history, a criminal record, or a history of substance abuse. Frequently, the behaviors exhibited by the at-risk youth are identical to those exhibited by a parent at some point in his or her life. For example, the pregnant teenager often has parents who had to get married; the suicidal youth may have had a parent or grandparent who tried to commit suicide; or the anorectic young girl may have a mother who was or may still be anorectic.

Underlying all of these difficulties and at-risk behaviors is a lack of rules and personal boundaries on the part of the adults as well as the youth. Frequently, the adults have fewer boundaries than the children, with the children acting in the role of a parent to their own parents. Parents who use drugs in front of the children, come home drunk, and don't go to work often have children who have not been attending school, have been caught with drugs, and are failing the 11th grade. Treating the at-risk youth has to involve treating the parents of severely dysfunctional families. The parents will have to face their problematic behaviors before the at-risk youth can face his or her problems.

Rules and personal boundaries are the issues to be considered in assessing the severity of the problems the at-risk youth and dysfunctional family exhibit. The higher the level of difficulty with rules and boundaries, the greater the level of risk and dysfunction. In addition, the more difficulty the adults have with rules and boundaries, the greater the risk for the youth. Therefore, the adult who constantly abuses drugs and alcohol has little understanding of the importance of basic daily responsibilities and parenting. The at-risk youth has a difficult time finding apporopriate role models in the home where he or she lives. The youth perceives mom and dad as constantly repeating, "Do as I say, not as I do!" Treatment with severely dysfunctional families is difficult. If the parents cannot or will not participate in changing the problematic family dynamics, the prognosis for improvement of the at-risk status of the youth is poor.

Moderately Dysfunctional Families

In the moderately dysfunctional family, the at-risk status of the youth is more difficult to discern and is not so readily apparent to the outside world. The personal profile of the at-risk youth is more dificult to interpret because of the seeming stability of the family. Each parent presents an appropriate image to the outside world; therefore, it is difficult to believe that there may be severe problems with one of the children. Below the surface, hidden from the community view, the family has difficulties it is not willing to reveal. The at-risk youth becomes the not-so-popular messenger, letting the comunity know that the family has secrets and is not perfect. There are flaws in the family photo, and the picture glass is cracked!

The advantage to the professional treating the moderately dysfunctional family is that the adults are typically able to function pragmatically on a day-to-day basis. Usually, they are competent in dealing with their job, pay their taxes, and generally follow the rules. However, as shown in the brief case history of Jim, the father had difficulty following the

rules of marriage while mother had great difficulty following the rules of sensible eating. The prognosis for the youth from the moderately dysfunctional family is better because the parents can more easily change some of their own behaviors, including parenting skills. The greatest problem is having the parents accept their portion of the responsibility for the dysfunctional family dynamics and not keep the focus solely on the youth.

Patterns of Behaviors in Dysfunctional Family Systems

After discussing the importance of family dynamics, the development of family dysfunction, and the evaluation of family dysfunction, it is most appropriate to utilize those concepts to present specific patterns of behavior in dysfunctional family systems with at-risk youth. By integrating the interaction of the dysfunctional family and the at-risk youth into six specific patterns, it is possible to present case examples, discuss typical therapeutic problems, and suggest treatment interventions and modalities.

At-Risk Adults Parenting At-Risk Youth

Probably the most important information that can be gathered at the time the at-risk youth is identified is the complete history of the family members, especially the parents. Frequently, the knowledge of the pathology the parent or parents in the past have exhibited can be helpful in the diagnosis and treatment of the youth. The adult at-risk behaviors seem to be transmitted directly to the children. Although the behaviors of an at-risk youth may be different from an adult's at-risk behaviors, the goal of the behavior remains the same—direct or indirect self-destruction (Farberow, 1980). The adult's self-destructive tendencies are not always suicidal, but rather entail making decisions that are not personally or professionally productive.

There are numerous at-risk behaviors that adults demonstrate to their children, and certain behaviors in their past tend to influence their interactions with the youth. Those adults who exhibited at-risk behaviors as teenagers, such as alcohol abuse, pregnancy, or eating disorders, frequently find themselves faced with offspring demonstrating similar, and at times, identical at-risk behaviors. It is not unusual to find that a pregnant teenager's mother was also pregnant as a teenager.

For the case presentation we will discuss Bill, a 16-year-old referred by the school for poor grades and suspected drug and alcohol abuse.

Bill came to the first session with his parents and presented himself as the basic noncompliant teenager. The parents, both from upper-class backgrounds, were quite concerned about Bill's academic problems as well as the difficulties they were having with him at home. Not only were there difficulties with school behaviors, but with even more severe problems at home. The parents found that Bill had been drinking, rather heavily, and most recently was brought home by the police for shoplifting at a mall near their home.

Although the family, including a younger sister of 14, were willing to attend the counseling sessions, not much change occurred during the initial stage of the treatment process. In fact, there were more drinking episodes, late night outings, and more shoplifting. Finally, one Saturday evening, Bill and his parents had a tremendous physical fight and argument at home that was reported to the counselor by Bill's sister. As suspected throughout the treatment process, both parents were heavy drinkers, even though both minimized their drinking when confronted by the counselor throughout the treatment process. This particular Saturday night, both had had too much to drink and found themselves in a brutal confrontation with Bill.

This particular case example demonstrates several important points. First, the parents had a severe drinking problem that directly affected the behavior of their at-risk son. Bill, like his parents, used drinking to escape his problems, avoid changing, and find excitement. Second, through shoplifting, Bill was able to inflict embarrassment on his financially successful parents. What better way to embarrass his family than by shoplifting, a poor school record, and drinking! Bill brought the family secrets to the surface for everyone to see.

When assessing an at-risk youth like Bill, the professional must examine the adult family members to determine possible at-risk behaviors that may be hidden from the community view. In this case, although both parents were highly successful in the professional and social arena, they both had drinking problems and came from families with alcohol abuse. Bill chose to use the at-risk behavior that had been used by his parents and their parents. Family history is crucial when assessing and treating at-risk youth.

During the treatment process, the professional has to encourage the parents to face their alcohol dependency before the at-risk youth can begin to change. In the case of Bill, once the severity of the parents' drinking surfaced, the couple was willing to admit to their problem and seek coun-

seling services for themselves. Once the couple began to examine their relationship and interactions, parenting Bill became a reality.

One final point about this case relates to Bill's sister. She became the parent and protector for Bill, very much at risk for a variety of potential problems herself. Therefore, everyone in the family needed counseling assistance to learn new patterns of interaction, to trust one another, and to support each other. Besides the identified at-risk youth, a sibling also may be having severe difficulties.

Interestingly, the transmission of at-risk tendencies from parent to child is much easier to assess with severely dysfunctional families. The at-risk tendencies become hidden in moderately dysfunctional families; therefore, the mental health professional must be astute and persistent and constantly probe to find the hidden at-risk behaviors of the adults. The lawyer and his wife, the professor and the saleswoman, or the successful business owner and his professional wife are not going to admit to their problems as easily as those families with known histories of alcohol or drug abuse, child abuse, and so on. It is extremely important to interview all members of the family thoroughly for the possibility of at-risk behaviors once an at-risk youth has been identified.

Parental Conflict and the At-Risk Youth

If parents are having difficulty processing conflict between themselves, the situation is likely to deteriorate into communication problems between the parents and extend to communication problems between parents and child. Secrets begin to exist between the parents, and the at-risk status of the child may be hidden from view by the poor communication of the parents. For example, one parent may know that the youth is failing a subject or drinks beer with his friends, but keeps this information a secret from his or her spouse. Obviously, the distrust between the parents creates an atmosphere where the children can manipulate one or both parents, but more importantly, the lack of respect between the parents is carried into the relationship between parent and child.

The conflict between parents leads to power struggles in parenting the child. Each parent attempts to structure his or her relationship with the child as an individual instead of as a member of the marital unit. Loyalty issues are pressed onto the child. For example, a teenager comes home after curfew and is grounded for 1 week by the father. After 2 days mother allows the teenager to visit friends but says, "Don't tell Dad!" This pattern of deceit between parents empowers the at-risk factors for the youth in two ways. First, the youth learns not to follow rules,

and second, the youth learns to be deceitful. The problems increase when the at-risk youth begins to encounter difficulties at school that pattern the problems of the parents at home. No longer can secret communications be used, and the family dysfunction appears for others to see. A case example will demonstrate the point.

> Ellen is a 15-year-old high school sophomore who was referred for treatment because of difficulties at school as well as home. The family consisted of mother, father, son, and Ellen. As Ellen would later report, her brother was Mr. Perfect, who never got into trouble. In the meantime, Ellen was failing various subjects at school, had been placed on curfew at home, and had been in difficulty in the local neighborhood. The culmination of the difficulties with Ellen occurred when she was involved in a teenage drinking party at her friend's house. At this party several of the teenagers became drunk and destructive, doing a great deal of property damage. Before Ellen and her friend could correct all of the problems, her friend's parents came home. Needless to say, both Ellen and her friend were severely punished and not allowed to see one another anymore.
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> After the "dust had settled," Ellen and her friend decided to run away with two other male friends from school. Because both of the girls had been leaving the house secretly without their parents' knowledge for the past year, sneaking away was not a difficult task. They locked their rooms before leaving, making sure their parents knew they were in the room, and ran off to a wooded area for 2 days. After 2 days, being hungry, they returned home. The parents were both relieved and angry.
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> During the counseling with the family, it became apparent that the communication patterns between and among the family members were ineffective. The family had moved on several different occasions because of job changes for Ellen's father. Ellen's anger at moving was known to the father, but not his wife's anger at him. Therefore, Ellen and her mother frequently had long, personal discussions about their desire to return to their previous home, but they never disclosed the intensity of these feelings to the father. In addition, Ellen's mother allowed her to smoke in front of her, drive the car without a license, and break her curfew without punishment. The close and inappropriate relationship between Ellen and her mother made it difficult to change Ellen's at-risk behaviors and kept father

"in the dark." The parental conflict over moving formed the basis for dysfunctional family dynamics and the at-risk status of Ellen. This case example points out two important areas.

First, it is almost impossible to discipline a youth having severe difficulties without complete cooperation between the parents. If the couple's relationship is not sound, parenting is a real difficulty. One parent undercutting the effectiveness of the other makes it impossible to bring about change. Therefore, the mental health professional must make sure that the family secrets between a parent and youth are known to the other parent, or the professional may find that a great deal of time is spent in counseling with little change occurring.

Second, loyalty issues between family members can create severe problems if the loyalty lines are inappropriately drawn. In the case example, Ellen's mother's loyalty was to Ellen and not to her husband. The appropriate loyalty for the couple's interests must be between husband and wife first, then parent and child. In the above example, the inappropriate loyalty on the mother's part created a system where the youth had parity and equality with the parents. Giving an at-risk youth that type of personal power in the home results in problems for the parents as well as for the youth. The role of the family counselor is to promote and assist the parents and the youth to develop appropriate loyalties and also to reinforce the need for the youth to follow established rules.

One final note needs to be mentioned about the difficulties created by divorce and the impact on the behaviors of the at-risk youth. To oversimplify a difficult and complex problem, let us say that a divorce happens when two people fail to communicate and resolve conflict. Following divorce, if a youth begins to exhibit at-risk behaviors, it usually takes a significant problem to force the parents to face the severity of the issues. If two people cannot communicate and resolve conflict while they are married, then why would anyone expect them to communicate and resolve conflict when they are divorced? The number of secrets both parents have kept is typically enormous because neither wants to be the parent that is accused of being inadequate in the care of the youth. Therefore, by the time that the at-risk youth is referred for care, the problem is usually critical.

In treating the youth of a divorced couple, it is important to remember to involve all important adults and children. The cooperation of all adults in the treatment process is a must if the youth is to improve and move beyond at-risk status. Without the involvement of both parents, and the stepparents when the two individuals remarry, the secrets, loyalty battles, and rule breaking will continue. The goal of therapy becomes

consistency in treatment of the at-risk youth, without reinforcement of the youth's manipulative behavior. Each parent, in his or her own home, must establish a set of rules, appropriate consequences, and appropriate rewards that satisfy the needs of the youth and the parent and stepparents. Consistency and congruence are the two words most often used in the cases involving divorced couples. They do not need to agree on the methods used in each other's home, but they must commit to being consistent and congruent within the parenting system developed in their own home.

Family Denial and the At-Risk Youth

The defense mechanism of denial consists of a process of not seeing problems or their intensity. During times when problems become evident, denial allows people to blame others rather than themselves. Therefore, denial is acted out in two ways in families. First, denial can be displayed by "burying one's head in the sand," not wanting to see the reality of the situation. Second, denial is displayed by "finger-pointing," blaming others for one's problems. Both ways of using denial lead to the potential for at-risk youth in a family. A case example will demonstrate the points.

> Jeff, a 17-year-old junior, was referred to counseling by the school psychologist for not attending classes. Jeff had had difficulties for the past 2 years in attending school, but because of his brightness, he was able to pass to the succeeding grade through the help of home-bound instruction and tutoring. However, by the time Jeff was brought for counseling in November, he had already missed 6 weeks of school. Jeff's parents had been divorced for 10 years, with Jeff residing with his mother and having very little contact with his father, who had moved to another state. Mother did not remarry, but father did.
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> After meeting Jeff and his mother, it was apparent that the relationship between the two was more like that of a husband and wife, rather than a son and mother. Jeff directed his life the way he desired, and although mother attempted to discipline him, he continued to do as he pleased. Later, after numerous attempts, the father came to one of the counseling appointments. He felt Jeff did not need therapy, but a "good kick in the seat of the pants," which the mother was not doing. In addition, the father told Jeff that he would give him money if he corrected the problem of not attending school.

Assessing all three characters in this drama demonstrates that Jeff, mother, and father all suffered from a poor level of self-awareness of

their impact on the problems exhibited. What was worse, none of the three wanted to accept responsibility or take partial ownership for the problems or make any attempt to resolve the issues. Ultimately, Jeff did not complete school, but was dropped from the school rolls.

The case of Jeff is a real tragedy. A young man with many talents who did not finish school, he chose to work at a service station pumping gas. Jeff and his parents had low levels of self-awareness and were unwilling to begin a concerted effort to correct a problem with a long history of frustration and failure. Both mother and father blamed each other, and Jeff blamed mostly himself, but at times felt his mother was the culprit. Regardless, all the parties involved used denial to avoid resolving the problems, with the ultimate victim being Jeff, a high school dropout.

It should be noted that denial is a common problem when counseling the at-risk youth and the family. It appears frequently with cases involving alcoholism, drugs, sexual promiscuity, and divorce. The helping professional is forced to proceed at a slow pace in an attempt to reduce the defensiveness and denial, in order to serve the at-risk youth. At times, the slow pace creates a therapeutic dilemma because the at-risk youth may need assistance more quickly, but the family's denial system is so strong that a severe problem has to arise to make the family face its problems. The severe problem can be an auto accident, drunk driving, a suicide attempt, school failure, and so forth. Counselors have to be patient, but constantly on the alert for the signs that the at-risk youth may give that indicate greater problems for the future. Sadly, at times, the denial will cease only following some type of personal tragedy of the youth.

The Parentification of Children and At-Risk Youth

One pattern of dysfunctional family dynamics that begins in the early years of child development is parentification of children. The pattern is related to parents who give responsibilities and privileges to younger children that would be more appropriate for older children or adults. The young children, by their actions and requests, maintain the control of the household and frequently dictate the mood of the entire family. Parents, fearful of disrupting the family calm, refrain from effective discipline techniques, allowing the child to have control of the family. A brief example will demonstrate a young child's power of blackmail.

> Kay, a 10-year-old, was referred for treatment by her mother and stepfather for serious behavioral difficulties at

home. Kay did not listen to her mother and objected vehemently to any attempts at control by the stepfather. Parents reported that Kay would not eat supper without some type of behavioral outburst that disrupted the meal for the entire family. In addition, whenever Kay was asked to do a task, like make her bed or do homework, she frequently became belligerent and upsetting. Needless to say, the family became very careful to not upset Kay and used bribery or whatever was necessary to keep her calm. Also, whenever major decisions were to be made regarding Kay's life, such as choosing a school, a doctor, or a vacation, she was given as much power as the mother and stepfather. In this way, the parents felt Kay could learn to be responsible for her life and make decisions that would keep her happy and calm. Kay used this power to blackmail her family by refusing to do things she disliked unless they gave her her own way. "You let me go over to my friends and I won't throw a fit at dinner!" At dinner she threw a fit, regardless of whether or not she got what she wanted earlier.

The intent of the example is to show the tremendous power children can gather through ineffective and inconsistent parenting techniques. The child, through the process of blackmail, controls the house. Later in life as the child approaches the teenage years, the extent of the control is massive. The at-risk youth begins the journey to difficulty as a very controlling and manipulative young child who has been given the power to make decisions that should be joint decisions of the parents and the child.

On the other side of the coin, a child can carry the burden of maintaining the well-being of the entire family. As long as the child is behaving well, giving attention to the parent or parents, and causing no apparent difficulty, life is fine. However, the child entrusted with this responsibility carries tremendous power and control. The burden can become intense as the child grows and matures. It is tiring always to be happy, provide love for a parent, care for the other children, and be an adult. The parents report that the at-risk child has never been a difficulty, but the ideal child who takes care of himself or herself and those around them. The parent never realizes the burden of such responsibility.

Children and youth want to be in control of the decisions that affect their life and will take every opportunity to gather more power. Parents must be encouraged to involve their children in the decision-making process, but be reminded that involvement is different than making a final decision. The final decisions in the life of the child or adolescent

belong to the parents. At times, parents want their children to be miniaturized adults, and are pleased when the child behaves like an adult. However, the parents need to be reminded that the children need to act in an age-appropriate manner and what may be "cute" now, may not be appreciated in the future.

Intrusive Parents and the At-Risk Youth

The intrusive parent gives the youth absolutely no privacy, checking everything from the mileage on the car to his or her bedroom belongings for clues of the youth's inappropriate activities. Typically, the intrusiveness begins when the youth has broken the trust of the parent-child relationship by being caught with marijuana, drinking, stealing, lying, or coming home late. After one or two of these "crimes," the youth's life is no longer private, but a public domain. In some instances, checking on the youth for possible signs of acting out that can be dangerous to the youth's well-being is appropriate. However, the intrusive parent goes far beyond simple observing to checking pockets in dirty clothes, going through notebooks from school, checking mail, reading notes from friends, and so on.

Frequently, the cautiousness and concern for the hidden aspects of the youth's life are directly related to the status of the parents' relationship. The parents do not trust each other and maintain a life that is exemplified by lies, deceit, and secrets. The following case example will demonstrate the dysfunctional dynamics.

> Jenny was a 16-year-old sophomore who was referred for counseling because of poor academic achievement and difficulties at home in following the disciplinary actions of her parents. One of the difficult issues for the parents was Jenny's friends, who they determined were inappropriate for Jenny and were the cause of all her problems. She was in frequent disputes with her parents over dances, trips to the mall, or any activity that she might attend where her friends could possibly be. Jenny's mother, in an attempt to curb her inappropriate activities, would read her notes from friends, monitor phone calls, keep track of the mileage on the car, and follow her when she left the house.
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> The parents were resistant to pursue counseling for themselves, expressing that the issues were Jenny's and not theirs. However, during a brief consultation with Jenny's mother it was learned that mother had had an affair of long standing that had recently ended. Father was unaware of the problem;

however, her mother had told Jenny. Although the parents knew their relationship was in serious difficulty, neither would commit to couples counseling.

The above case demonstrates the severe problems involved when the parent or parents become overly intrusive in the child's life. Typically, the intrusive parent has difficulty in establishing appropriate boundaries between him- or herself and the children. In this case, the mother gave the daughter very little distance on the one hand while on the other she shared inappropriate information with her about her private life and relationships. It is clear that the at-risk youth armed with such powerful information about a parent can cause serious and continuous disruption in the family.

In addition, as demonstrated by both parents in this example, there is an overemphasis on the parent-child relationship with too little attention given to the parent-parent relationship. The at-risk youth becomes an extension of the conflicts between the parents. The parents refuse to deal with their issues, becoming overinvolved in the youth's difficulties. In the meantime, the youth is attempting to force the parents to deal with real issues surrounding their marriage.

Along with having difficulty with boundary issues, the parents attempt to protect the youth from the natural consequences of his or her actions. The protective nature of the parents arises from the guilt they feel about the lack of stability in their marriage, from the ineffectual way they have handled their life, and from the failure they feel as parents. Whenever the youth has a problem, the parents attempt to fix it rather than letting the youth suffer the consequences for his or her actions. Parents will complete homework, pay the cost of damage to cars, and lie to the school about absences. Parents model the exact behaviors for which they are criticizing the youth. The youth is taught to "do as I say, and not as I do."

Serious Illness of a Parent and the At-Risk Youth

The final family system to be discussed relates to those families where one of the members has a serious illness, such as leukemia, kidney failure, heart problems, or similar life-threatening problems. Within this family structure and communication system, the family never completely discusses the problem or is open about the extent of the difficulties the problem may cause the individual or the family. For example, a youth may learn from his biology class or health instructor that the serious heart ailment his father suffers has a genetic link. If the family has not discussed the future implications with the children,

the impact of such information on the youth can be traumatic. The youth, upon learning such crucial information, is someone who must be considered at risk.

The lack of communication about the serious illness promotes a family system that on the one hand is based in secrecy, deceit, and dishonesty, while on the other, is emotionally charged. Family members tend to overreact to simple problems, parents are protective of the children, and in general, the entire family is oversensitive. However, the sensitivity and emotionality are related to the serious illness, which is rarely discussed, while the attention is placed on less serious problems and concerns. Denial is a major aspect of the dysfunctional family communication system. The following case will demonstrate some of the difficulties the treatment of the seriously ill client presents.

> Mary, a very bright and gifted high school student, was brought to counseling because of concern about potential suicide. Her parents had been seen for counseling for several months because of the serious difficulties the father was having because of kidney failure. He had been on dialysis for some time, and the prognosis was not good. His life expectancy was less than 6 months. Both mother and father were attempting to come to peace with his eventual death in the near future. In the process of coming to terms with the problems, the parents were overprotective of the children, refusing to discuss the seriousness of the father's illness in an open and honest fashion.
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> Mary presented herself as a depressed youth who was taking an existential view of life and death. One of her beliefs was that the meaning of life was defined by death. Mary had very little information about her father's illness; however, she could be susceptible to the illness as she got older. There was the distinct possibility that she would inherit the same difficulty as an adult. The mysteriousness surrounding her father's problems created an atmosphere of depression, death, and sadness that Mary seemed to absorb like a human sponge. She was not sure why she felt the way she did, but an observer could see that she was the family's emotional leader.

Once the family began to discuss openly the seriousness of the father's illness and his impending death, Mary's serious at-risk behaviors began to subside. She was able to be supportive of her parents, begin to examine her potential problems, and plan for the future while both parents were still alive. The secretiveness that is inherent in a family like Mary's will tend to create many problems for all the family members,

not only the seriously ill member. Although it can be frightening to discuss such severe problems with the children, it is a must. Before the death of the ill family member, each other family member needs to be given the opportunity to present whatever they want to the ill person and vice versa. Obviously, this interaction frequently needs to be mediated by a professional, but it a good way to relieve the pressures the entire family feels.

In the case of Mary, following the death of the father, the family continued in counseling. The entire family was better able to discuss the loss, make plans for the future, and begin life without the father. Without the openness displayed by the parents and children, resolution of the death would not have been possible, especially for Mary. Being relieved of the family's emotional burden permitted Mary to grow, develop, and progress through high school as normally as possible for someone suffering such an emotional loss.

In summary, there is much overlap across the six patterns of behavior that have been discussed. The interaction between dysfunctional family dynamics and at-risk youth is complex and multidimensional. This is because human behavior does not readily lend itself to categorization and simplification. The goal of the discussion is to provide helping professionals with some cues that may be of use with at-risk youth and their families. It is important to see at-risk youth as a product of their family dynamics.

Role of the Helping Professional

The role of the professional, whether employed in a school, agency, or private practice, is important and well-defined. In working with the at-risk youth and dysfunctional family, the mental health professional must be sure to "follow the rules" of the treatment process. Just as the at-risk youth attempts to alter the rules in other settings for personal gain, the youth will attempt to have the professional alter, change, and ignore the rules of the treatment process.

For example, the youth may have a simple request, such as asking the professional to write an excuse that would allow him or her to miss a class at school or be permitted to miss detention. Other, more critical violations of the rules may be requests for emergency appointments late at night or over the weekend. One high school principal from a rural district spent 6 hours with a youth along a country road following a phone call requesting her help. It was very considerate of the principal, but also very risky and ethically questionable. The youth would not follow the rules, and the principal reinforced the breaking of the rules.

If an at-risk youth needs help, it is the professional's responsibility to determine the most appropriate treatment for the youth. Meeting a suicidal youth on a country road at 10 o'clock at night is not an appropriate treatment process. Following the rules means having a crisis team available to give the youth the appropriate treatment, and possibly hospitalization. If the youth is really suicidal, then a coordinated professional effort needs to be utilized to resolve the problem.

Basically, professionals need to follow the rules, just as they advise their clients. Not following the accepted professional process places the client in a precarious position and leaves the professional vulnerable. But even more importantly, at-risk youth do not like to behave in typical ways; therefore, the professional must not behave like the youth's family system that permits the youth to continue to violate requirements that others follow without question.

Determining Level of At-Risk Behavior

The first responsibility of the professional is determining the severity of the at-risk youth's actions and interactions. Whether the youth is abusing alcohol, is pregnant, or is a runaway, the professional needs to determine the extent of danger to the well-being of the youth. With youth, we take very few risks, because they tend to be impulsive in their actions and prone to hurting themselves physically. Professionals tend to follow a process that involves three basic aspects (Palmo & Palmo, 1988).

Duty to warn. If the at-risk youth is a danger to him- or herself or others, ethically and legally the parents *must* be alerted to the extent of the problem (Palmo, Langlois, & Bender, 1988). At the initiation of counseling, the at-risk youth and the family are both informed that any suspicious or questionable behaviors will be reported. Confidentiality and at-risk status are both clearly defined early in the process, reinforcing the professional's responsibility to follow the rules. If there is a question about the level of severity of the behavior the youth exhibits, professionals need to follow a very cautious route and involve the parents. The sooner the at-risk youth and the family are involved in treatment, the greater the opportunity for successful resolution of the problems.

Parent consultation and encouragement. As mentioned in the previous section, the parents must become actively involved in the process of treatment as soon as possible. Providing an effective consultation with the parents will assist the family in understanding the necessary steps of the treatment process. It is very important for the professional making the initial contact, whether a school counselor or community mental health counselor, to provide the family with a clear understanding of the

helping process. The initial consultation should be used to encourage and assist the family in receiving the most effective services possible. If the initial consultation is a positive experience, more than likely the family will be ready to pursue the necessary steps of the treatment process.

Referral. Finally, if the professional cannot provide the family with the appropriate services, he or she must refer the family to an appropriate agency, institution, or private practitioner. Frequently, the at-risk youth is identified by school officials, but the services required for treatment are offered elsewhere. Therefore, the schools must develop comprehensive referral relationships with local agencies, practitioners, and hospitals (Palmo & Palmo, 1988; Palmo, Langlois, & Bender, 1988). Networking among all community mental health professionals is a must for the successful treatment of at-risk youth.

The three aspects of the professional's role outlined above are important. Each mental health professional needs to understand the principles underlying the concepts of duty to warn, consultation, and referral. Treating at-risk youth and their families requires a complete understanding of these three concepts.

Treatment Modalities

When examining the treatment possibilities for at-risk youth, two important assessments must be accomplished. One is the assessment of the youth and the other of the family structure, dynamics, and functioning. We firmly believe that the most effective approach to treatment during the time that the youth is most at risk, that is, suicidal, involved with drugs, or pregnant, is a combination of family and individual counseling. For most cases we use the combination of individual counseling of the youth while at the same time undertaking family counseling. Remember, the at-risk behaviors are the direct result of the dysfunctional family system; therefore, some aspect of the treatment should involve the family.

There are exceptions to the basic rule of using family counseling as the primary treatment modality. For example, when the at-risk youth becomes too great a danger to him- or herself, hospitalization may be the primary treatment of choice. More than likely, however, the most frequent reason to choose another treatment modality arises when the level of dysfunction in the family is so great that effective family counseling is almost impossible. When the relationship between the couple is questionable, the parenting skills are almost nonexistent, one parent is an alcoholic, or the parents are frequently absent from the home,

developing an effective treatment plan is difficult if not impossible. A brief case example will demonstrate this.

> Mark, an 18-year-old senior, was referred for counseling on two different occasions, both following behavioral outbursts at school, followed by outbursts at home. He was brought to counseling by his mother because the father was absent from the home for weeks at a time due to work responsibilities. Each time Mark came for counseling additional appointments were scheduled with the mother for the two of them. However, when the appointment arrived, neither came for counseling. Mark's violent temper and tremendous mood swings had been occurring since he was a young boy. The family had involved the police as well as the neighbors on several occasions, but the parents would never commit to counseling on a regular basis. Mark had attempted suicide by hanging the summer before school started, but even that incident did not bring about a change in the family's attitude about counseling for Mark.

The above case demonstrates that it may not be possible to provide the most desirable treatment for an at-risk youth because of the problems presented by the dysfunctional family. In Mark's case, the school psychologist took over the primary counseling role, because the only time Mark could be seen for treatment on a consistent basis was during school hours. The unwillingness of the parents to accept the responsibility for the care of their child often makes family treatment an impossibility.

Couples Counseling

Frequently, one of the most effective treatment modalities to bring about change in the youth is couples counseling. If the parents can commit to working on their relationship, along with being willing to learn different parenting approaches with their children, the chances of successfully assisting an at-risk youth increase significantly. As demonstrated throughout the case studies, frequently there is such disarray in the relationship betwen the couple that it is understandable why the youth may be having emotional difficulty. Parents who work too much, drink too much, or allow their lives to be out of control provide an inappropriate model for the developing youth. Once the parents can be taught to reorient and redirect some of their energies, the positive changes in the youth are absolutely astounding. Therefore, couples counseling along with family counseling can produce tremendous changes in the dysfunctional family structure.

Networking

Probably the most important professional responsibility for the counselor treating at-risk youth is maintaining a comprehensive referral network of helping professionals. This should include both medical and nonmedical mental health service providers. Referral sources need to include psychiatrists, drug and alcohol counselors, clinical psychologists, marriage and family specialists, and in some cases, the clergy. The professional treating at-risk youth must be an integral part of the school and community in order to provide the most comprehensive services possible.

As presented in a more comprehensive form elsewhere (Palmo & Palmo, 1988), we believe that professional networking is the only effective method for treating the at-risk youth. Because the at-risk status can be defined in many varied ways, the mental health professional must have an effective network of other professionals in order to offer the youth and the family the best services possible. Networking is a safeguard for the clients as well as the professional.

Recommendations

There are several final recommendations to consider when determining the treatment process for at-risk youth. As the counseling professional approaches the treatment of the at-risk youth, he or she must always remember to involve the parents. In some cases, the parents may need to be the primary focus of the treatment process before changes can occur in the youth. In any case, comprehensive services must include the parents in the treatment process.

A second recommendation for each professional is to be totally schooled in the ethical and legal aspects of treating at-risk youth. Each professional needs to be fully aware of his or her responsibility to the youth and the youth's family. The Corey, Corey, and Callanan (1988) text presents an excellent overview of the issues and concerns involved in treating at-risk clients. Another aspect to consider in treating at-risk youth is confidentiality versus keeping dangerous secrets. Too often professionals maintain confidentiality without considering the ramifications to the client as well as to themselves. Being direct and "upfront" with the youth about the types of information and behavior that are treated in a confidential manner versus those to be reported to the parents helps avoid potential problems later in the treatment process.

In treating the family, the professional must maintain a neutral position and avoid being in a position of being on someone's side. The

youth and the parents will both attempt to enlist the counselor's support in their attempts to maintain the dysfunctional family system. Phone calls by the youth or a parent, bringing damaging evidence to the session to demonstrate someone's problem, or asking for additional sessions is representative of some of the "influence peddling" family members try. No matter what the individuals attempt, the professional must maintain a neutral status and support the development of a new and functional family interaction system.

Finally, in order to treat effectively the myriad difficulties at-risk youth and their families present, the professional must maintain a high level of self-confidence. Treating at-risk youth and their families can be a substantial test of the professional's self-confidence; therefore, appropriate attention must be given to taking special care against stress, anxiety, and maybe even burnout. Each professional must make a commitment to his or her own mental health in order to maintain the energy needed to treat the at-risk client. Using professional colleagues for support and consultation, making effective and necessary referrals of particularly difficult cases, and seeking personal counseling when the stress becomes too great are some ways a professional can maintain a high level of self-confidence and effectiveness.

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Chapter 4

BODILY ASSAULT: PHYSICAL AND SEXUAL ABUSE

Robert H. Rencken

Why? The question is asked again and again.

Why is the fragile shell of childhood cracked, broken, shattered by abuse?

Humpty Dumpty is pushed off the wall. Who can put him together again?

The complexity and pervasiveness of physical and sexual abuse swirl before us, almost daring us to try to arrest it. Both causes and effects are insidious and intangible; barely discernible at times and devastating at others. We look at the troubled or at-risk youth with one eye and see a victim; with the other eye we see an actual or potential offender.

The complexity of the problem, in fact, obscures our ability to adequately define and quantify it. What is abuse? Who is the victim? Where are the limits? How bad is bad? Who reports what to whom? The impact of abuse is difficult to measure because of varying incidence factors (particularly reporting differences) and varying effects. These effects may be felt immediately after the abuse or not until weeks, months, or years later. As the reader will see in this chapter, physical and sexual abuse are clearly major risk factors for children and adolescents.

This chapter, specifically, will look at the incidence and effects of physical and sexual abuse, the dynamics of abuse, the youthful offender, and strategies for intervention. Intervention strategies will be reviewed for both immediate and delayed timeframes. Three case studies will be presented to illustrate these dynamics and interventions.

Incidence

Physical Abuse

In reviewing incidence studies in physical abuse, Justice and Justice (1976) reported a range of 37 to 63 cases of physical abuse per 100,000 children but cautioned that the number of reported cases was increasing. A later review of estimates noted ranges from 200,000 to 4 million cases per year (Goldstein, Keller, & Erne, 1985). The American Humane Association (AHA) (1981) showed that 750,000 children were *reported* as abused or neglected and that there was an increase of 15.7% over the previous year. The AHA data show that major physical injuries were reported most frequently in young children (less than 3 years old) and older children (12–16 years old), with about equal proportions of male and female victims.

Sexual Abuse

Finkelhor (1984) reviewed incidence studies related to sexual abuse. Incidence rates, rather than actual numbers, are reported with rates ranging from 5% to 9% for boys and 8% to 38% for girls. Finkelhor effectively points out that even if no more than 10% of girls and 2% of boys were abused, clearly a conservative estimate, there would be over 200,000 new cases of sexual abuse each year.

We also know that sexual abuse is primarily committed by men (Finkelhor, 1979; Bell & Weinberg, 1978). Men abuse about 95% of female victims and 80% of male victims. The most common age for victims is 8 through 12, but with many cases outside that range (Finkelhor, 1984). Most female victimization occurs within the family, whereas boys are more likely to be abused outside the family (Finkelhor, 1984).

Conclusions

We are at a point of using a new rule for describing incidence factors for both physical and sexual abuse: Imagine the worst scenario, then accept the reality that it's worse than that. Despite the media hype we frequently see as *over*stating the problem, several factors point toward *under*reporting:

- Much of the work with survivors and victims involves retrospective reporting, discussing past incidents that were never originally reported. This is particularly true in sexual abuse. These reports

include relatively recent (10 years) incidents that clearly would have fallen under mandatory reporting.

- Increasingly severe penalties for the offender, particularly for sexual abuse, discourage children from reporting or testifying against a family member.
- We, as adults, are so uncomfortable with the problems that we would rather ignore them and not "get involved."
- The victimization of boys is particularly repressed by our societal sexist beliefs that only girls are victims, only boys are offenders, and boys can't cry, (or tattle or feel or care) and have to learn to "take it."
- We frequently "blame the victim."
- Children are not believed.

I'm often asked if there is a greater incidence of abuse or if it is "just" being reported more. In my clinical experience, the answer is "Yes."

Clearly, we are a society that continues to abuse, exploit, and victimize those that are less powerful. Unfortunately, the consensus is that children are too often the targets. But even when they are the targets, they are not the only ones to feel the impact. Child, family, and society all take the blows and feel the violation.

Effects

Most of us, despite our societal lethargy, are concerned about the children, the victims of physical and sexual abuse. Sometimes, the damage is obvious—the bruises, the scars, the ultimately violated, lifeless body. Most of the time, however, the damage is not so visible. Recent research clearly confirms the effects of abuse. Physical and sexual abuse have been linked, for example, to illicit drug use in adolescents (Dembo, 1987) and multiple personality disorder (Coons, 1986).

Physical Abuse

Physical abuse, specifically, is thought to affect children by creating behavior problems and reduced social competencies (Wolfe & Mosk, 1983); lowered self-esteem, antisocial behavior, and suicidal tendencies (Galambas & Dixon, 1984); acting out, depression, generalized anxiety, extreme adolescent adjustment problems, emotional-thought disturbances, and helplessness-dependency (Farber & Joseph, 1985); fewer friendships and less ambition (Oates, 1985); poor peer relationships,

social skills, and empathy (Lamphear, 1985); aggressive tendencies (Graybill, 1985); and delinquency, depression, attachment disorders, and sexual abuse (Steele, 1986). Broader effects on intellectual, cognitive, social, emotional, and linguistic development were noted by Cicchetti and Beeghly (1987) and Cryon (1985). Neurological abnormalities were reported in 53% of a sample of abused children (Martin, Beegley, Conway, & Kempe, 1974). Children have also been observed to develop patterns similar to abusing parents (aggression, isolation, and lack of empathy) as early as at 1–3 years of age (Main & Goldwyn, 1984). Abused children have been noted to have little confidence in their ability to influence or have control over their own experiences (Barahal, Waterman, & Martin, 1981). These data may be among the most critical because they underscore the concept of the physical abuse cycle. Among abusing parents, 30% to 60% say they were abused as children (Justice & Justice, 1976). The exact manner in which this cycle is created certainly varies from one case to another, but clearly the child receives messages that violence is necessary and productive, "might makes right," and that children are powerless possessions of parents. These messages are apparently so strong that they overwhelm the "logic" that those adults who were abused as children should "know better." The ultimate irony is that physical abuse may be the biggest cause *and* effect of physical abuse.

Sexual Abuse

The effects of sexual abuse specifically have been linked to difficulties in healthy sexual functioning and self-esteem (Burgess, Holmstrom, Groth, & Sgroi, 1978); runaway behavior and delinquent/criminal activities (McCormack, 1986); lowered confidence, fewer friends, more aggression, increased sexual awareness, and behavior and academic problems (Tong, 1987); and prostitution (Silbert & Pines, 1983).

The intergenerational effect in sexual abuse is less clear than in physical abuse, primarily because of its currency and lack of longitudinal research. Finkelhor (1984) noted that much of the research that points to an intergenerational cycle has been done on convicted offenders, perhaps not a representative sample. Clinical experience, however, shows that many offenders do not disclose, or even explore, the possibility of victimization until well into the treatment process. This may actually result in an underestimate of the number of offenders who had been abused.

Sexual abuse has one specific but complex effect on many victims—sexualization. Sexualization refers to a developmental anomaly created by inappropriate exposure to sexual contact. Although it could be rooted

in unusual exposure to sexually explicit media or adult-adult sexual behavior, it is likely to occur as a result of sexual abuse. This experience results in an artificial acceleration of psychosexual development. For example, the victimized 11-year-old shows the flirting and dating behavior of a 16-year-old while, of course, retaining the cognitive, physical, and social development of an 11-year-old. The sexualized child is clearly at risk for sexual behavior, early pregnancy, and sexually transmitted diseases.

Conclusions

The impact of physical and sexual abuse is not easily quantifiable but is clearly seen in school and clinical settings and supported by the clinical experience of counselors and others. Some effects are:

1. The loss of trust, security, and the essence of childhood;
2. Ambivalence and conflict of feelings—love and hate, rage and guilt, stoicism and fear;
3. The creation of defenses: walls of denial, repression, and dissociation, the armor of anorgasmia, anorexia, and obesity; the weapons of the fist, the tongue, and the belt; the retreat to the bottle, the pill, and depression; escape from the family, society, and reality; and
4. Death, frequently invisible, unnoticed, unmourned, by overt or covert suicide.

The frustration, or course, is that we don't/can't/won't deal with abuse until these time-bomb symptoms explode, and even then we don't link these with abuse unless we ask the right questions of the adolescent or adult sitting in front of us. Like with underreporting, we probably underestimate the damage of abuse to the child and the child within the later adult.

Damage to the family is less often noted. The strained dysfunctional marriage (or adult-adult relationship) is both a cause and effect of abuse, with the reported incident frequently acting as the crisis precipitant of divorce, separation, or abandonment. The nonoffending spouse, if there is one, becomes torn by guilt, fear, and anger, forced into the divided loyalty of spouse and mother, like the TV juggler with the apple, bowling ball, and chain saw. The siblings of the victim (if they are not yet victims themselves) not only are fearful for themselves but also defend against this by blaming the victim, for if the victim "deserved it" or "asked for it," then the offender can still be loved and trusted. Even extended family is drawn into the fray, sometimes as supporters, sometimes as blamers, sometimes reliving their own guilt as past abusers.

The damage to society is detailed throughout the other chapters of this volume, for as abuse affects the child, it becomes a (or the) major contributor to problems of suicide, self-esteem, sexual acting out (and related problems of pregnancy and sexually transmitted diseases), eating disorders, runaway behavior, and so forth. Societal costs are economic (protection, prosecution, punishment), productive (loss of earning potential, long-term costs of disability), and structural as its familial foundation crumbles.

Dynamics

Everybody asks "Why?" The victim, the offender, the family, the teacher, the physician, the judge, the taxpayer, and persons who are going to be abusers themselves for the first time *today*—all ask "Why?" It would be wonderful if abuse could be discussed in terms of a misplaced gene or a hormone run amuck or a mysterious tumor. It can't, and it doesn't go away. The more we explore, the more we find patterns (not profiles), clouds (not clarity), questions (not answers), and rather reasonable-appearing individuals and families (not deranged sociopaths and perverts). There are no definitive answers.

Physical Abuse

We live in a society that not only tolerates but also condones the hitting of children. We teach spanking of children in order to break their will (Dobson, 1970), use corporal punishment in our schools, the societal institution that is supposed to model relationships with children (Maurer, 1972–1978), and generally devalue children and childhood (Elkind, 1987). We are also a society that values violence and advocates violent solutions to problems (*TV Guide*, any week). Obviously, we should not be surprised that physical abuse exists. But we *are* surprised!

Physical abuse may come from either parent and may be directed at one or more children, frequently in a repeated pattern, and is typically accompanied by abusive language and humiliating punishment that may not be physical (Justice & Justice, 1976).

The dynamics of the physically abusive family are reviewed by Justice and Justice (1976), who integrate seven models—psychodynamic, personality or character trait, social learning, family structure, environmental stress, social-psychological, and mental illness—into an eighth model they term "psychosocial systems." This goes beyond the family system to include the components of the other models, from internal to external influences. The abusive family is seen as having

difficulty coping with changes and shifts that occur in systems, particularly those labeled as life crises. The family is frequently isolative, with poor support, and enmeshed; that is, fused within itself into a rigid system. Such families are then unable to handle children's behavior problems, particularly in combination with other stresses.

These dynamics produce what Bowen (1966) described as undifferentiated individuals. These undifferentiated adolescents are those that we consider to be at risk and likely to repeat the cycle of abuse, as well as the other behavioral effects noted earlier.

Sexual Abuse

A similar set of dynamics also applies to intrafamilial sexual abuse. These families are seen as isolative, rigid, and conservative/traditional in their style (Finkelhor, 1979; Herman, 1981). They tend to devalue or discount communication and depend on clear power structures. They are not cohesive and adaptable (Alexander & Lupfer, 1987).

There are some patterns, of course, that are specific to sexual abuse and more complex. The research and clinical experience in this area are more recent and hampered by societal bias and language/jargon confusion. Although much of society condones *some* hitting of children, there is universal contempt for *any* sexual contact with children (even sexual abusers detest other sexual abusers). It is interesting that the roots of this contempt may well have more to do with out societal negativity toward sex than with our desire to protect children.

Like other stereotyping processes, language reflects society's negativity. Terms like *molester, pervert, deviant,* and others even more hostile, prevent us from understanding and solving the sexual abuse problem. I have proposed using the term *pedosexual* to refer to any sexual contact between an adult and a child.

Pedosexual behavior is a heterogeneous grouping with different family and psychodynamic issues. In this chapter, the focus is on intrafamilial sexual abuse because it is the most common form, but the reader should also be aware that youth may also be victims of:

- Pedophilic contact, where the offender has a compulsive arousal pattern to prepubertal children;
- Rape, where physical trauma and violence may inflict additional problems;
- Addictive sexual behavior, where the child may become an "outlet of opportunity"; and
- Extrafamilial contact, where the offender may or may not be previously known to the child.

Intrafamilial sexual abuse may have rather differing systemic patterns. These patterns represent different ways in which the role boundary that divides adults and children in a healthy family is violated. That boundary may be violated by: (1) a dictatorial father, who sees spouse and children, equally, as possessions for his sexual gratification; (2) an immature/dependent/irresponsible father, who becomes like one of the children by exhibiting irresponsible work, relationship, or substance abuse behavior; and (3) a pseudoadult child, who is encouraged to become a substitute mother/spouse.

Societal dynamics are also clearly important in sexual victimization because it is clearly an offense committed by men against (mostly) women. Even when men are victims, there is still the concept of sexual objectification, the use of those less powerful for sexual gratification (Finkelhor, 1984; Russell, 1986).

Conclusions

Both physical and sexual abuse create current and future problems for the child that may be related, in intensity, to the amount of coercion and conflict involved. Finkelhor (1984) emphasized the impact of coercion on the future adjustment of sexual abuse victims, noting that prognosis seemed better, for example, for children who were verbally seduced as compared to those who were physically intimidated or threatened with weapons. The coercion factor applies similarly to physical abuse victims.

What is less clear is the component of emotional conflict. Clinical experience has shown the tremendous energy behind the love-hate dilemma of abuse victims. Children in both physically and sexually abusive families retain affection for each parent even while fear and anger stir beneath the surface. It seems that the greater this love-hate conflict, the more difficulty the child has in resolving abuse issues. This conflict may be felt more often in sexual abuse situations where the behavior may seem less hurtful or painful to the child, also increasing the probability that the child feels guilty about "enjoying" the abuse. In both types of abuse, the child may also feel that he or she "deserved it," again increasing the guilt and confusing responsibility issues.

Why does one family create physical abuse whereas another creates sexual abuse? Or both? The answer is not clear. There is no clear profile for offender, nonoffending spouse, or children in either abuse situation. What does seem to be common between the two are consistent issues of control and power. In either situation, the parents are likely to feel a significant lack of effective power and control. They attempt to gain, or regain, some of that power and control through dominating the children, which results in a transient feeling of power but also feelings of guilt

that perpetuate the original feelings of powerlessness and loss of control. On the contrary, but to a lesser extent, the children in both situations may be imbued with a false sense of power that actually increases their vulnerability.

With both power and control as central issues, it may well be that sexual abuse is differentiated by the sexual nature of the behavior. This sexual component may or may not include specific sexual arousal to children, but does include the previously mentioned objectification. This sexual component may be added to the basic power and control issues through previous victimization, societal sex negativity, problems with intimacy or sexual dysfunction, or a combination of conditioning factors.

The Youthful Offender

Another unique component of sexual abuse dynamics is the emergence of the youthful offender. Clearly, this is a topic of interest for those working with at-risk youth. Some offenders are even prepubertal.

The issue of sexualization leads to the discussion of the offender-as-victim-as-offender. Although exact numbers are hard to determine, clearly a majority of youthful offenders have been victims themselves although, perhaps, untreated. Although the effect of sexualization is the biggest factor here, the dynamics of the victim of abuse are similar to those of the offender in this age group—isolation, alienation, and lack of intimacy. The sexualization acts as the magnifying glass, focusing these dynamics into a pedosexual contact.

How does victimization turn into offending? Certain clinical observations may provide helpful information. The pedosexual behavior is likely to be limited to genital touching, although there may be other sexual behaviors such as exhibitionism or voyeurism. The victim is likely to be prepubertal and known to the offender, whether intra- or extrafamilial. The young offender is likely to have a history of physical or emotional abuse in addition to sexual victimization. This may reflect a generally chaotic family structure, sometimes held together by rigid rules and expectations. The offender may be rather compliant, withdrawn, and isolated from peers. Asocial behavior is more likely than antisocial behavior. There may well be gender identity or sexual preference confusion. There may also be a generalized preference for nonsexual contact with younger children.

We are struck by a picture of low self-esteem and inadequacy in the young offender, particularly in dealing with peers. There is also a probability of school adjustment difficulties. Obviously, if there has been sexual victimization, most of these noted patterns could be exaggerated.

The youthful offender clearly has unique concerns. Much more clinical experience and research are needed in order to address these concerns.

Interventions for Physical and Sexual Abuse

Typical intervention approaches in the physical and sexual abuse arenas have been family-based. This is particularly true as counselors work with at-risk youth. The specific intervention strategy is, of course, going to depend on the situation. Counselors know, however, that family dynamics issues, whether past, present, or future, will have a big impact on their work. Regardless of the specific strategy—individual, family, or group; therapeutic or educational—family issues need to be addressed.

Intervention strategies involving the victim of physical or sexual abuse are similar enough to be grouped together in a chronological sequence for this discussion. Exceptions will be noted. Within this broad strategic approach, many specific techniques may be utilized, and counselors may well find themselves utilizing several different techniques, approaches, and modalities on any given case.

Therapeutic models include play therapy (Long, 1986; Oaklander, 1978; Sgroi, 1982); mother-child bonding (Damon & Waterman, 1986; Giaretto, 1982); family systems therapy (Friedman, 1988; Giaretto, 1982; Gelinas, 1988); group therapy (Porter, Blick, & Sgroi, 1982; Blick & Porter, 1982; Delson & Clark, 1981; Justice & Justice, 1976), and others. Educational models were reviewed by Goldstein et al. (1985) to include control and interpersonal skills and improved parenting. The strategy described will include components of all those approaches.

In order to be implemented effectively, any of these approaches should include some clear, underlying philosophical assumptions. These assumptions are necessary because both physical and sexual abuse test the limits of our ability to be objective, empathetic, and nonjudgmental.

These assumptions include:

1. The problem is treatable. The victim becomes the survivor.
2. The victim carries *no* responsibility for the abuse but can assume responsibility for recovery.
3. Acceptance of feelings and provision of support are consistently necessary.

Immediate Intervention Strategies

Intervention strategies are either immediate or delayed, the latter occurring 1 year or more after the last abusive contact. Clearly, indi-

vidual case situations determine specific strategies, but experience has shown the need for different approaches for these timeframes. Counselors may, of course, become part of (or withdraw from) the intervention process at various points.

The counselor may be one of the first adults to hear of abuse. This awareness may be direct (observation of, or verbal report from, the child) or indirect (another child, a friend's parent, teacher, or school nurse). The task of the counselor remains the same: Report the abuse and support the victim.

The report must not only be made because of legal mandates but also because the protection of the child has to be the highest priority. The child should be told that a report will be made. The report, in fact, validates the child's self-worth and right to protection.

During the session when the child initially discusses the abuse, support takes precedence over interrogation. The tendency to press for details may be neither helpful nor necessary. The counselor should avoid "playing police" and focus, instead, on reassuring the child of having done the right thing and accepting the child's feelings of fear, anger, guilt, ambivalence, and confusion.

Although counselors can have a positive impact during this crisis intervention phase, the *primary* focus has to be on protection of the child. This is *not* the counselor's role, rather that of the Child Protective Services or law enforcement. The counselor can assist the protection process, however, by providing accurate information about the child and supporting the child through the often confusing maze of "the system."

"The system" includes law enforcement agencies, child protection departments, attorneys, courts, and probation offices—any one of which could be intimidating to children. The counselor, acting either as primary therapist or supportive counselor, can play a critical role in providing assurance to the child that any feelings will be accepted. This should be done without unduly predictive statements from the counselor like "Everything will be better," or "Don't worry, he'll be going to jail," or "You'll be going home soon," which may not turn out to be accurate.

Although specific feelings may be somewhat different in physical versus sexual abuse situations, there may be even more variation from one individual to another. Whereas physical abuse may primarily trigger fear and anger/rage reactions, sexual abuse also includes an increased probability of guilt. The sexual abuse victim seems to have wider swings from fear to rage to guilt. The latter is the most difficult for many adults to understand. The affectional bond between parent and child remains more intact than we anticipate, compounded by the child's natural egocentricity, which results in the perception that the cause of the family's problems is the report rather than the abuse.

The guilt a victim experiences is so strong that the counselor should assume that there is a suicide risk in every case and monitor that possibility during crisis times. The critical phrase here sounds something like, "They'd be better off without me," or "I'm the cause of all the family's problems." The suicide risk is particularly high in adolescents, but all members of the family should be considered to be at risk.

The key to dealing with this fear, rage, and guilt, particularly during the crisis stage, is a focus on "the child." These feelings are *all* "OK for kids" and *totally* acceptable. The children can have an appropriate sense of relative powerlessness in order to emphasize their lack of blame, fault, and so forth. They can retain this developmental role of child and still build appropriate power. At this point, the "permission" to feel is critical.

The counselor can be an advocate for, and supporter of, the child without "offender-bashing." Counselors risk involving their own biases of anger and disgust toward the child abuser, which only adds to the child's confusion. Instead of being in an adversary relationship with the offender(s) and the rest of the family, the counselor can begin the process of systemic intervention here in the crisis phase. The counselor can provide (or coordinate with other involved counselors/therapists) support to other family members: encouraging the treatment process, providing a safe venting space, providing information when possible, and making referrals. It may not always be possible to make this systemic intervention (e.g., if the parents deny the abuse). If such is the case, the child will clearly need the primary support of the counselor.

Clarification of roles and responsibilities. The second stage of intervention requires more emphasis on the family system. The systems approach acknowledges that the whole family, with all its internal and external influences, has set up the structure and dysfunction that led to the abuse, either physical or sexual. The systemic framework can be helpful even if the counselor has access only to the child.

As noted previously, the issues of dysfunctional role boundaries, inappropriate division of power, and gender role stereotypes are all a part of the destructive family system. Because the whole family has been involved in setting up these patterns, it's not surprising that statements arise like: "Mom pushed him to do it with her nagging," or "Rickie deserved to be hit," or "Susie liked the attention," or, the classic rationalization, "Everybody knew about it but nobody did anything." These statements are frequently used not only by the offender, but also by the whole family. So who's really the "bad guy"?

It may be helpful to look at the tricky concept of dual responsibility. First and foremost, the abuser is *one hundred percent* responsible for the choice to give up control and cross the line of appropriateness regardless

of the actions or reactions of the child. This is essential to emphasize—100%.

There is, however, a separate and distinct responsibility the whole family has for having established the patterns and atmosphere that existed at the time of the abuse. The adults (parents) have a major share of that responsibility—the marriage relationship, parenting behaviors, financial and household management. All the children, to a lesser degree, also have their share of responsibility for family functioning. This notion of family/system/corporate responsibility enables the counselor to enlist the whole family in mutual empowerment and responsibility for changing the maladaptive behavior, a very powerful, positive force.

Accepting this responsibility is difficult for many families and resistance to treatment is typical in this phase. This is voiced as, "Let's forget the whole thing and put it behind us." Even the victim is likely to cooperate with this resistance which, if allowed, would plunge the family back into their old dysfunctional patterns.

The major goal of this treatment phase is to return the child to the appropriate child role in the family by expressing feelings, receiving nurturance and protection, and taking an age-appropriate share of responsibility. One of the most powerful tools for accomplishing this is through the apology/confrontation sessions, also perhaps the most challenging sessions for the counselor.

The apology sessions are a series of structured confrontations between the victim and abuser and may also include the nonabusing spouse and others in the family. Sessions are similar whether or not the family is together or whether it even will be reunifying. The first of these sessions should take place as soon as the child is ready, and the bulk of them may occur during the middle stages of treatment.

The child must have a good sense of being protected before attempting a direct or indirect confrontation. This includes having discussed details of the abuse with his or her counselor and having acknowledged (probably not yet resolved) the feelings. The child should have a sense of having a support system whether or not he or she really "wants" the confrontation. Both child and abuser should be specifically prepared for the session by role-play or similar techniques.

The initial apology session should include the child, the abuser, the spouse, child's counselor, and abuser's counselor (if different). The child can be shown the room and introduced to the abuser's counselor if either are not previously known, and the child can set the seating arrangement for comfort. If the child and the abuser have been physically separated for some time, the initial contact may be anything from a "cold" stare to a cheerful hug. The abuser will be encouraged to apologize for the specific behavior of the abuse as well as its "set-up." Respon-

sibility issues will be clarified, and the report to authorities will be acknowledged as a positive and necessary action. The child's responses, although frequently not predictable, will nevertheless be reassured as "OK." Further apology sessions will focus more on details of the abuse, patterns that set it up (including substance abuse and communication issues), and the "family secret" dynamics.

There are many cases, of course, where this direct confrontation is not possible. The same basic goals apply in an indirect confrontation: expressing feelings, clarifying responsibilities, and creating protection. Strategies include role-play (with counselor, with dolls, other counselors in the support team), Gestalt techniques (empty chair, pillow, doll burial symbolism), writing or dictating letters (or drawing pictures), which may or may not be sent to the abuser, or other expressive play (clay, paints, etc.). These confrontations, even if indirect, should still be structured, with clear closure points.

Empowerment. The third focus of treatment is empowerment. This focus is not necessarily time-defined but is, rather, a sequence of tasks that proceeds through the whole treatment process. The basic sequence of empowerment used by this author is:

1. Reinforcement of the report;
2. Rebonding with the nonabusing parent;
3. Assertiveness and self-protection;
4. Redefining the relationship with the abuser;
5. Resumption of age-appropriate roles whenever possible; and
6. Positive control and attitudes regarding violence (physical abuse) or sexuality (sexual abuse).

The imbalance of power is one of the key elements in setting up both physical and sexual abuse. The child is powerless against the physical, verbal, and affectional power tools of the adult. Children may show this powerlessness in seemingly contradictory behaviors—one child becoming withdrawn, isolated, and helpless; another acting out sexually or aggressively and rebelling at school.

Regardless of the behavior, the roots are the same—powerlessness and anxiety. These effects may be doubly traumatic when one considers that in many families these children are given unusually powerful, responsible, pseudoadult roles before the abuse.

After the abuse, the child may use inappropriate power techniques to regain the perceived loss of power. Parents can try to deal with this through typical techniques such as limit-setting and explaining consequences. They also, however, can use positive approaches to *empower* the child, reducing the child's need for unproductive power. The first time for emphasizing this positive power is at the time of the report.

The report can, of course, be a scary time because it is a powerful "weapon" for protection. The child needs strong reinforcement that the report is a reasonable and appropriate process, and that now adults will be responsible for his or her protection.

The nonabusing spouse will, it is hoped, be the most important "protector" of the child, therefore, this relationship needs a special focus in order to accomplish "rebonding." This dyad should receive special focus in treatment and visitation, continuing to meet as a dyad at various times throughout the treatment process.

One of the most difficult goals of empowerment is obtaining a balance between assertiveness and self-protection on one hand and aggressiveness and dictatorial power on the other. The child does have the capability for self-protection and the right to privacy of his or her body, including the right to "say no" while maintaining the child role in the family. The basic message is similar to what we would give to an adult—"Taking care of myself does not infringe on the rights of others or relieve me of social or familial responsibilities." This focus on assertiveness is facilitated greatly through peer group work.

It seems obvious that the child's relationship with the offender must be redefined. A great deal of society would redefine the relationship by separating the two—by either incarcerating the offender or removing the child. There are other options. Through the combination of individual, dyad, triad, and group treatment as well as carefully monitored visitation, a major shift can occur in that relationship.

One frequent question professionals and others ask is how the victim (or any of those involved) can possibly "forgive and forget." The truth is that they don't. And they probably shouldn't. One analogy that may be helpful is that the abuse, like other traumatic events, is eventually "filed away"; that is, abusive incidents certainly continue to exist as memories but, with time, are removed from daily routines. There may be times, of course, when the files are pulled back out so that some issues can be handled. This "filing" analogy allows victims and families to get on with their lives while still acknowledging the reality and responsibility involved, rather than using denial and minimization that exemplify the pathology.

The last focus in the empowerment process is a reinforcement of positive control. For the physically abused child, this includes information and modeling that demonstrate that problems can be resolved without violent physical means. For the sexually abused child, there is also the need for correct and *complete* information about sexuality (despite possible parental resistance), including anatomy and physiology, sexual response, contraception, values, psychosexual development, relationships, and societal attitudes. The child also should receive strong mes-

sages about (1) the need for consensuality and lack of harm, in contrast to his or her own experiences, and (2) the concept that being in positive control over self also includes a positive control over his or her sexuality. Empowerment, then, includes the concepts of positive, assertive control and responsibility, as well as appropriate feelings of power.

Group methods. The use of group work can be an important part of a planned intervention, as well as a prevention mechanism. Groups may be focused on self-help and mutual support, education, counseling/therapy, or a combination thereof. They may be oriented toward children (victims or siblings), parents, or whole families. Structured self-help groups such as Parents Anonymous for physical abuse and Parents United for sexual abuse provide national networks for support and education and may be a helpful resource.

Parent groups were described by Otto (1984) and Devoss and Newlon (1986). Damon and Waterman (1986) provided a highly structured parallel play group model in which mothers and children meet separately and together with an emphasis on bonding/rebonding.

Delayed Intervention Strategies

The counselor working with at-risk youth, whether in the school, mental health program, or other settings, typically has the benefit of dealing with the abused child within a year of the last abusive incident. Because many children are abused in their preadolescent years and the abuse is not reported, there are situations in which the counselor may be dealing with a delayed intervention even though the client is still only an adolescent. The strategies for delayed intervention are similar whether the client is male or female, adult or adolescent, with some individual variations.

The overriding issue in delayed intervention is that, to a greater or lesser degree, the child has built up defenses to cope with the abuse. Although these defenses may initially have been functional, they will probably present significant obstacles to both identification and treatment of affective, relationship, and sexual issues.

The first obstacle is the presenting problem. With delayed intervention, the presenting problem seldom *seems* to be related to the abuse. Typical issues for adolescents include peer fighting, running away, sexual behavior, substance abuse, or withdrawal. These issues, of course, are also typical for nonabused adolescents. Do we assume that all children have been abused? Not exactly—but close!

For abused children, a general question about family functioning such as "How are things going at home?" may trigger anxiety and secretiveness. Even if this kind of question doesn't elicit strong reactions,

the counselor can use general permission-giving statements such as "Lots of times kids tell me about scary (painful/unusual/inappropriate) things that have happened to them. Sometimes things have even happened a long time ago." A follow-up permission statement may be something like, "Sometimes parents hit kids (pause) or yell at them a lot (pause) or touch them where it doesn't feel good (pause). Kids talk to me about that kind of stuff." The permission statements should remain that and not turn into interrogation. Permission may act like a seed that bears the fruit of a later report.

In the delayed intervention, counselors often ask whether they are still mandated to report the abuse to authorities. Because there are generally no specific time exemptions in reporting laws, the general answer is still to report the abuse even if CPS or law enforcement chooses not to take action. They may make their decisions based on the need to protect the identity of the abuser, type of abuse, and so forth, but this is not really the counselor's decision. If the victim/survivor is over 18 at the time of the report, mandatory reporting would not typically apply, but the counselor may still have an ethical obligation to report if other children are, or may be, at risk.

Clarification of issues and empowerment. If the victim/survivor acknowledges a history of abuse, the counselor may still have to exercise patience in allowing details to surface through consistent permission and encouragement, again without interrogation—"You've told me about your father touching your breast. Sometimes remembering that gets you thinking about other things that may have happened."

Because of the strong defenses seen in delayed intervention, there is frequently a strong emotional conflict that has been repressed. As noted earlier, this conflict (affection vs. rage, love vs. hate, pleasure vs. disgust, guilt vs. anger, fear vs. intimacy) is a major treatment issue and should receive extra attention from the counselor. The client may be resistant to exploring this conflict.

That same repression and resistance may also apply to feelings in general. Affective awareness may be an important goal, especially if there is indication of dissociative behavior. Clients may report an inability to feel pleasure or anger. One of the tragic ironies in these cases, for example, is the young woman who engages in sexual behavior often but is not orgasmic. Counselors may find themselves spending considerable time and effort exploring feelings that may or may not seem relevant to the abuse.

Clients, particularly adolescents, may express strong reservations regarding the possibility of reconciliation or reunification. They can be reassured regarding their safety and need for protection. They can also be encouraged to use the counseling process for their own psychological

confrontation and reconciliation (see previous section on the apology process). They can be given the option of bringing out the unresolved issues, dealing with them, and then "filing them away," all with the emphasis that they have control over the process and, in fact, their life.

Group methods. One final strategy in delayed intervention is the use of group structures, both support groups and therapy groups. Although groups may generally be valuable treatment modalities for both victims and abusers, they are particularly valuable in delayed intervention. Mutual support, especially during psychological confrontation, is critical, as is reinforcement for affective awareness and empowerment. Self-help groups such as Parents Anonymous and Parents United may again be helpful here.

Case Studies

Three case studies will be presented to illustrate typical cases, treatment strategies, and outcomes. Abuse cases, of course, are heterogeneous and demand individualized planning. These cases illustrate that variety and some similarities. They are actual cases with slight changes for confidentiality, without exaggeration.

Case 1—Maria

Maria is a 6-year-old girl, an only child, who came to school with a handprint on her left cheek which, she said, came from her mother's slapping her at breakfast. The school nurse reported to Child Protective Services while the counselor reassured Maria and stayed with her during the CPS investigation. Because the CPS files included multiple abuse, Maria was transported to a hospital for evaluation and then to a temporary shelter facility. Medical evaluation revealed a previously broken wrist. Parents acknowledged the reported incident but denied chronic abuse and were extremely angry at the school and CPS. Follow-up police/CPS investigation alleged that both parents were physically abusive and that the mother had a history of alcohol and cocaine abuse. They were not arrested. Maria was declared a dependent of the state by juvenile court and placed in foster care, and the parents were mandated into treatment.

The initial treatment plan included individual (play) therapy for Maria, conjoint counseling for the parents, substance abuse monitoring for the mother, and participation in Parents Anonymous. Early treatment reports on Maria indicated that she was withdrawn, anxious, and unwilling to talk about the abuse. Doll and puppet play was family-oriented and paintings were mostly rainbows, flowers, and suns. Parents contin-

ued to deny the chronic abuse for 3 months after the report and then, over a 4-week period, unfolded the history of abuse during counseling and Parents Anonymous sessions, discovering that they each knew only about half the abuse that the other had committed. Supervised visitation began after they acknowledged responsibility.

The treatment plan was modified to include individual therapy for each parent. An initial apology session was held, with the parents tearfully acknowledging responsibility for the abuse. Maria, on the other hand, showed little emotion during the apology session, although she seemed to understand and accept the parents' apology. It was also reported that Maria was stealing food and small amounts of money in the foster home. Maria didn't respond verbally to these allegations to the foster parents or in play therapy. She did, however, engage in abusive puppet play and drew colorful but heavy-pressured designs. The therapist treated both the behavioral and symbolic indicators of anxiety by encouraging the expression of feelings and reframing choices in many areas of Maria's life.

Six months after the report, Maria was less anxious in therapy, with improved adjustment noted in school and the foster home. Two more apology sessions had focused on Maria's adjustment and the parents' responsibility. The treatment plan was shifted toward dyad (marital) and triad sessions focusing on roles and responsibilities. Visitation was expanded to include unsupervised visits with the parents.

Nine months after the report, the family was reunified, although the dependency status was maintained for another 6 months, with continued periodic counseling. The parents chose to maintain participation in Parents Anonymous.

Five years later, mother initiated counseling for herself subsequent to divorce. She had remained drug-free and sober and reported no further abuse incidents. Maria was functioning very well. Mother had given birth to a boy, now 3 years old. The parents were given joint custody. This reinitiation of counseling successfully dealt with mother's concerns about her coping skills, issues regarding relationships, and career planning.

Case 2—Jason

Jason is a 9-year-old boy who was voluntarily turned over to Child Protective Services by his father and stepmother on grounds that he was dangerous to his younger sisters (ages 5 and 2) because of physical attacks, one alleged attempt at setting fire to the 5-year-old's bed, and fondling and oral sex with both younger sisters. They had previously relinquished custody of Jason's 11-year-old sister after she had appar-

ently initiated sexual contact with him, the 5-year-old, and at least two children in a day-care center. The father and stepmother had reluctantly assumed custody of the three oldest children about 18 months ago, after the children were removed from the mother's custody in another state. In that investigation it was alleged that mother performed mutual oral and manual sex with Jason and his older sister and forced these two children to perform oral sex and coitus with each other in front of a group of adults. She would severely spank Jason (more intensely than the others) and afterwards "make up" for the spanking by fellating him. Mother was charged with sexual abuse but fled the state to avoid prosecution. The father and stepmother acknowledged increasingly severe physical punishment of Jason but denied sexual abuse (this was corroborated by the children). They refused participation in treatment and eventually permanently relinquished custody of all three oldest children to the state.

Jason was placed in foster care and individual therapy was initiated. He was in five foster placements in 4 months because of his behavior, including fondling younger children, urinating and defecating in corners, and stealing. Individual therapy included attempts at appropriate expression of feelings (verbally, and through art and play), trust-building, and limit-setting. The individual therapist also provided supportive counseling to the foster parents. Jason was also placed in a self-contained class for the emotionally handicapped.

A stable foster placement was arranged after 4 months and continued for 2 years, at which point the (natural) parental rights were severed and the foster parents adopted Jason. During this 2-year period, individual therapy continued with the same treatment goals, expanded by a focus on the sexual issues, anxiety/rejection concerns, clarification of roles, and self-esteem improvement. Foster parents were seen regularly. The sexual and aggressive behaviors continued for about a year but decreased in frequency. During this time, there was an increase in telling of lies, mostly denial of wrongdoing. There was at least a monthly coordination among the therapist, foster parents, CPS case manager, and school personnel.

By the time of the adoption, Jason's behavior had stabilized. For a 6-month period, there had been no sexual behaviors, with problems limited to stealing and lies.

Treatment continued for almost 1 year after the adoption (total of almost 3 years since referral), with alternating individual and family sessions focusing on communication, self-esteem, and behavioral issues. Jason continued in his special education placement. The case was closed by Child Protective Services.

Case 3—Kathy

Kathy is a 16-year-old girl who was referred by juvenile court. She had been arrested for prostitution and possession of marijuana and cocaine. Court investigation revealed that she had been engaging in street prostitution for almost 2 years and had been using marijuana, cocaine, and alcohol for at least 3 years. She had been in counseling regarding her substance use/abuse. Physical or sexual abuse was suspected but Kathy denied it. Her family had moved since she had run away and could not be located by authorities. She was in detention at the beginning of treatment.

Kathy was initially resistant to treatment, denying problems and minimizing both her substance use and negative effects of the prostitution. She stated that she was living independently and adequately and didn't want counseling or other intervention. She was offered the option of a female therapist but said she felt more comfortable with a male therapist. To circumvent her resistance, she was given the opportunity to choose the topics for counseling. She initially vented anger at "the system" and then at her "boyfriend," who apparently had "dumped" her.

In the twelfth session, Kathy acknowledged more general problems in relationships with men/boys. She said she wanted a deeper relationship with one man despite the attention and physical pleasure she received from the serial sexual contacts. She tearfully acknowledged, however, that she had not been orgasmic. This, in turn, led to her revelation that she had been sexually abused by her stepfather from age 9 to 13, on a consistent (weekly) basis including coitus (for the latter 2 years), fellatio, cunnilingus, and mutual digital-anal penetration. She reported significant guilt over both the behavior and the report because she remembered enjoying, and even initiating, the sexual contact. The reassurance process was started at this session and continued for several sessions, focusing on the stepfather's responsibility.

After informing Kathy, a report was made to Child Protective Services, although no formal investigation was made because of the inability to locate the stepfather. Ninety days after her arrest, Kathy was released from detention and placed on probation and into a group home. She was also ordered into outpatient substance abuse treatment and monitoring.

During the 10 subsequent sessions, Kathy was increasingly able to discuss her anger and rage, as well as the guilt involved. She also reported difficulty in peer relations in the group home, with verbal and physical fighting and reluctance to follow group rules. She remained "clean and sober" and continued to deny substance abuse.

Approximately 6 months into treatment, Kathy was arrested for possession of marijuana after running away from the group home. She was detained for 48 hours and then placed into another group home. She reported little remorse for this behavior but agreed to refrain from substance use during treatment. Emphasis was placed on her own responsibility to control her life regardless of the abuse history. She seemed to develop a good therapeutic rapport and was able to discuss various problems relating to her, and her family's, history.

Eight months into treatment, after being restricted by the group home parents, Kathy ran away. Two years later, there was no indication of her whereabouts or condition.

The Challenge

The author hopes that this chapter has clarified the difficulty of dealing with physical and sexual abuse. Whether the intervention is immediate or delayed, abuse issues are complex, heterogeneous, and volatile. They require unusual sensitivity, flexibility, and objectivity on the part of the counselor, whether in the role of primary or supportive therapist.

The counselor may fill several, sometimes overlapping roles in dealing with abuse: primary therapist, support team member, advocate, or prevention and education specialist. All are valuable. The primary therapist typically provides individual counseling/therapy to either victim or abuser and will also be a part of the dyad/triad/family/group processes.

The supportive counselor provides ongoing encouragement and in some cases, practical support for the victim and family. This counselor may be in the school, Child Protective Services, family support/welfare office, or career planning service. The support team, with these members, the primary therapists, Child Protective Services, adult or juvenile probation, and medical providers may make (or provide input into) decisions regarding visitation, treatment planning, or reunification. As a part of this support team, or within the legal/child protective/criminal justice system, the counselor may become an advocate for the child. Advocacy may be necessary to ensure protection, obtain services, and provide for the child's best adjustment.

The school or mental health counselor may also provide, or consult regarding, prevention and education. This may include specific abuse issues (body privacy, protection, etc.) or more general topics (self-esteem, communication, sex education, assertiveness, gender/family roles).

The counselor also needs to be able to deal with a team approach, with its attendant frustrations and logistical difficulties, especially be-

cause some individuals and agencies (CPS, law enforcement, etc.) may not be therapeutically oriented.

The counselor should be particularly cautious about recognizing his or her limitations in this area. Even the experienced specialist in the field will frequently refer individuals or families in order to maximize the therapeutic relationship and goals.

The effects of physical and sexual abuse are so pervasive that their presence should be assumed in the majority of adolescent problems until they are definitely ruled out. This can be done routinely, without negative impact on the counseling relationship.

Despite the difficulties, dealing with the abused (and the abuser) presents an important and potentially rewarding challenge. Changes are frequently dramatic and lasting, with many families not only improving from their earlier dysfunction but also actually becoming healthier than "average" untreated families.

If there is one arena where all treatment is truly prevention, it is physical and sexual abuse. Counselors, I believe, have the unique combination of philosophical base and clinical skill to make a major impact on this problem. But first, we have to open our eyes, ears, and hearts!

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Chapter 5

"WHO CARES WHAT I THINK?": PROBLEMS OF LOW SELF-ESTEEM

Sandra S. Meggert

Low Self-Esteem and At-Risk Youth

Joan is 15 years old, is experimenting with drugs and alcohol, is failing most of her classes in high school, seems anxious and depressed, and is threatening to drop out of school. Her parents have talked to the counselor, teachers, and the principal. In turn, each has talked with Joan, but no one seems to be able to persuade her to change her behaviors.

Andy, 16, is withdrawn, has no friends, is not doing well in school, often refuses to attend school, won't talk with his parents or the counselor about himself, and when anyone tries to penetrate his isolation he responds with, "I don't care," or "Leave me alone."

We observe many adolescents in pain. We see many with negative attitudes or low self-esteem and suspect there are many more. Many researchers believe that one of the major causes of deviant or potentially destructive behavior is low self-esteem (Kaplan, 1975; Leung & Drasgow, 1986; Yanish & Battle, 1985). A review of the literature supports the belief that negative self-esteem affects behavior in negative or destructive ways (Aronson & Mettee, 1968; Graf, 1971; Kaplan, 1975; Kaplan, Martin, & Johnson, 1986; Lorr & Wunderlich, 1986; Yanish & Battle, 1985). Kaplan (1976) stated that poor self-esteem or "negative self-attitudes increase the probability of later adoption of each of a range of different types of deviant responses" (p. 788).

Low self-esteem is a critical factor in at-risk behavior. Eskilson, Wiley, Meuhlbauer, and Dodder (1986) reported that adolescents who feel excessive demands to succeed academically are apt to disclose

involvement in deviant activities, to have low self-esteem, and to feel inadequate and unable to fulfill their families' aspirations for them. Aronson and Mettee (1968) used college students as subjects in a study of dishonesty. They hypothesized that students with "low self-esteem are more likely to engage in immoral behavior" (p. 74). Results showed that 87% of the subjects with induced low self-esteem cheated on a test as compared to 60% of the neutral group and 40% of the induced high self-esteem group. In a similar study, Graf (1974) reported that 40% of those with induced low self-esteem, 17% of the neutral group, and 14% of the group with induced high self-esteem engaged in dishonest behavior.

Kaplan's (1976) theory suggests that low self-esteem influences a person to adopt delinquent or other behaviors that are deviant from the norm. The theory identifies two routes that negative self-attitudes may take to influence deviant behavior. One is that these attitudes make conformity to membership group patterns painful or distressing; the other is "by influencing the person's need to seek alternatives to the disvalued normative patterns in order to satisfy the self-esteem motive" (p. 788).

The results of a study of adolescents at risk for compulsive overeating (Marston, Jacobs, Singer, Widaman, & Little, 1988) showed that students designated at risk perceived their life quality as poor, and the authors hypothesized that this meant they are getting along poorly with the person to whom they feel closest. Because self-esteem is closely tied to perceived evaluations from significant others, the quality of significant relationships is a crucial ingredient of self-esteem. The research findings of Yanish and Battle (1985) support the importance of significant others to the adolescent. They found depression in adolescents to be more strongly affected by the relationship with parents than with peers. A longitudinal study by Cohen, Burt, and Bjorck (1987) indicated that low self-esteem and depression, an indicator of low self-esteem, are positive predictors of controllable negative events, for example, expulsion from school.

Simmons, Burgeson, Carlton-Ford, and Blyth (1987) stated that young people who encounter several important life events at the same time they are adjusting to the changes of adolescence are expected to be at greater risk than those who have longer periods of time to adjust to adolescence. Findings in this study show that girls suffer loss of self-esteem, and both boys and girls show declines in GPA and participation in extracurricular activities. For girls, each subsequent life change brings more difficulty with coping. The authors suggest that, in terms of self-esteem, this group of young adolescents would do better if one aspect of their life were comfortable. If this were accomplished, then the timing and pacing of major changes would be of primary importance.

As discussed in the many preceding examples, adolescents who exhibit signs of low self-esteem may be considered at risk for adopting or experimenting with deviant or potentially destructive behaviors. These young people may or may not be responding to life situations with deviant behaviors currently; however, when the signs indicate low self-esteem, interventions designed to improve self-esteem are important to help them avoid at-risk behaviors.

The purpose of this chapter is to examine low self-esteem as one of the primary causes of the at-risk behaviors described above, and provide a framework and strategies to help create positive levels of self-esteem. This is accomplished by defining self-esteem in relation to at-risk youth. Immediately following the definition are some behavioral descriptions frequently linked to low self-esteem, some factors that influence the development of self-esteem, and four phases of interventions with low self-esteem populations, specifically students. Examples of intervention strategies for each phase are included. A case study demonstrates the phases of intervention, and additional successful programs are identified.

Definitions of Self-Esteem

Self-esteem refers to subjective evaluation of worth. These value judgments develop through personal success or failure experiences, interactions with others, maturation, heredity, and social learning, and are formulated from an individual's perspective. Kaplan (1975) discussed the self-esteem motive as being an individual's need to optimize positive feelings about self while reducing negative feelings. It is the process of increasing feelings of self-respect, approval, worth, and esteem. When the balance is on the negative side, a person is said to feel self-rejection, self-derogation, and, in many cases, self-hate.

Self-esteem is also a function of perceived evaluation by significant others. Mack and Ablon (1983) believe that no human is ever totally independent of the evaluation of others, and everyone retains "to some degree, a dependence upon connectedness with others for validation of our worth" (p. 10). A person's self-evaluation is referred to as self-esteem (Robinson-Awana, Kehle, & Jenson, 1986). It is influenced by the individual's feelings of competence and efficacy. Two other terms are sometimes used interchangeably with self-esteem, *self-concept* and *self-acceptance*.

Self-concept refers to the perception individuals have about their personal attributes and the roles they fulfill. Some of these perceptions are accurate, and some are not. We receive feedback about the roles we play and internalize information about the character and quality of

our role performance (Beane & Lipka, 1980). "Self-concept refers to descriptive perceptions of self while self-esteem refers to the valuative assessment of those descriptions" (p. 3). For example, individuals have an academic self-concept, a social self-concept, or a physical appearance self-concept. Elliott (1988) maintained that anyone with low self-esteem has an unstable self-concept. The term *self-acceptance* pertains to the degree to which people are comfortable with their self-concept (Frey & Carlock, 1984).

For purposes of this discussion, self-esteem is defined as the pattern of beliefs an individual has about self-worth. It is the subjective part of self-concept, the evaluation of self, and behaviors based on an individual's perceptions of personal experiences and feedback from significant others. It is expressed in feelings of power or helplessness, called efficacy, or in beliefs about personal control.

Indicators of Low Self-Esteem

Beliefs about self develop as a result of perceptions and evaluations of success and failure experiences. In this process, an individual forms some beliefs about personal control (internal vs. external) and personal effectiveness (self-efficacy).

Locus of control refers to a person's belief about outcomes. Locus of control is the conviction that (a) success or failure at a task is internally determined by one's own actions or ability, or (b) the outcome is due to external influences such as luck, fate, or chance. According to Johnson (1981), "internal attributions for success are associated with higher levels of self-esteem" and low self-concept "was predicted independently and significantly by internal attribution for failure and external attribution for success" (p. 174). Abramson, Seligman, & Teasdale (1978) suggested that low-achieving students ascribe any failures to internal causes and all successes to external causes.

Personal effectiveness, or self-efficacy, as defined by Benoit and Mitchell (1987), has four essential elements: *awareness* of required behavior to bring about success, *expectation* that this behavior will be successful, *belief* that there is a relationship between behavior and outcome and that this behavior will have an impact, and that the outcome provides something *valued*.

Evidence supports the fact that an individual with low self-esteem would most likely believe in luck (external control) rather than ability (internal control) to achieve success. On the other hand, failure is attributed to personal shortcomings (internal control). Because self-esteem judges whether an individual can, in fact, succeed at a given task, the

lack of belief in self makes it likely that someone with low self-esteem will also exhibit feelings of helplessness or powerlessness, in other words, low levels of self-efficacy. In this case, a possible defense might be to deny that the outcome of the behavior has any value, to withdraw, or to drop out.

Individuals with low self-esteem often find it necessary to develop defenses. People who have low self-esteem hurt. To avoid this hurt there is a tendency to shun experiences such people believe will bring additional pain or to change these experiences in some way. They erect barriers or defenses. At times the individual might be hostile, critical or suspicious of others, or lack identification with others. Sometimes retreating defenses are exhibited when a person avoids coming to grips with problems or denies reality (Kaplan, 1975). A person might retreat into an "I don't care" stance or simply resist trying. It is too much of a risk for someone with feelings of poor self-worth to be exposed to additional hurt or situations where failure is expected.

Persons with low self-esteem may be distractible, timid, shy, withdrawn, inhibited, anxious, less academically able (Domino & Blumberg, 1987), and have a narrow range of interests. They are more likely to daydream and to want to find jobs where they have little or no supervision and where there are minimal amounts of competition. From their perspectives, an ideal situation is where they will have no supervision because then no one can confirm their failure. Generally, they express the idea that they do not really want to get ahead in life. This could be because they will not place themselves in a position where they expect to fail. This too is a defense.

Individuals with low self-esteem have few coping strategies. They often feel a lack of control over life events. They don't feel connected or have few, if any, expectations of future success. They lack a sense of belonging. Possibly, dropping out is a defensive way of demonstrating some power, self-defeating though it may be.

Low self-esteem can cause emotional distress as well. Many individuals who question their worth are sad, lethargic, tense, anxious, and angry. Some of these feelings stem from concurrent feelings of helplessness and powerlessness. Physically they may exhibit sleeplessness, headaches, or nightmares.

Those with low self-esteem are generally dissatisfied with themselves and their lives, are contemptuous of self, and have low levels of self-respect. Typically, they are fearful of new experiences, have a poor physical appearance, and a low energy level. Apologizing, criticizing others, showing an interest in material things, and bragging are all indicators of low self-esteem.

There are parental, social, psychological, physical, environmental, and cultural influences on self-esteem. Several of these factors and their effect on self-esteem are briefly described on the following pages.

Parental Influences on Self-Esteem

Frey and Carlock (1984) identified a representative list of "psychological pathogens" to self-esteem (pp. 25–31). Many of these are associated with parental influences. These "pathogens" may persist throughout life and, if so, may consistently keep self-esteem low unless someone or something intervenes. Some examples from their list, along with problems that might arise when these are present during childhood, follow:

1. *Expecting perfection.* Nobody has achieved this state yet, but there are a lot of people trying! Carrying a burden of "always trying to be perfect" out of childhood guarantees failure. Those who have learned to set idealistic or unrealistic goals for themselves are constantly frustrated, critical, and impatient with themselves and others, always trying harder and never quite feeling successful. Negative self-evaluations, which are formulated by the individual from perceptions of adult reactions, deeply affect their feelings about self. Unless a person learns to set realistic goals and acknowledge small steps on the way, self-esteem will remain low because the person will never feel adequate.

2. *Inconsistency and failure to set limits.* Though some people believe consistency is a myth, children often search for consistency and limits, apparently seeking the security that structure and predictability provide. When that is missing, the result is anger, insecurity, and hostility.

3. *Failure to give positive feedback.* Many parents and significant others assume that children know positive behavior is appreciated and only respond to negative or improper behavior. Being constantly reminded or punished when behavior is inappropriate and seldom being appreciated when behavior is appropriate creates feelings of inadequacy and inferiority.

4. *Failure to listen.* Failing to listen to a child indicates a lack of respect and communicates that the child or what the child is trying to communicate is not important. When this feeling is carried through childhood, it fosters additional feelings of inferiority and inadequacy that are sometimes expressed in anger or hostility.

5. *Rejection.* Consistent rejection critically affects an individual's self-esteem. The rejected child's basic needs are not being met, in some cases, deliberately. Death, divorce, severe illness, or being ignored can

all be viewed as rejection by a child, with the ensuing feelings of inadequacy, guilt, self-hate, or self-rejection.

6. *Being a maladjusted role model.* Children who model their behavior after an adult who is maladjusted often end up disliking themselves because of those behaviors. Their self-esteem is greatly diminished in such cases.

7. *Failure to help children adapt.* Societal and cultural values are being questioned more now than ever before. It is difficult for children to feel adequate in a society where values are shifting or unclear. It becomes even more difficult when children try to adapt to a different culture where values conflict.

8. *Forcing children into a pattern.* Sometimes parents try to fit children into certain behaviors or patterns that may restrict their unique development or be beyond their capacity. This is sometimes called "living vicariously" and creates frustration and feelings of worthlessness and inadequacy in both parent and child.

9. *Allowing and supporting procrastination.* Believing that one does not have the self-discipline necessary to complete a task contributes to poor self-esteem. The longer the child procrastinates, the more the feelings of inadequacy and worthlessness multiply. Concurrently, there is a loss of self-respect.

Frey and Carlock listed several additional pathogens and observed that "one can be the recipient of several of these dynamics" (p. 31). Each of these or a combination of several can be detrimental to a child's self-esteem.

Social Influences on Self-Esteem

A basic assumption in social psychology is that self-concepts are heavily influenced by social contexts (Bachman & O'Malley, 1986). Each of us has a long history of dependency during infancy and childhood where we needed to receive positive responses from adults. We were motivated to behave in ways that increased the likelihood of receiving these positive responses. As children we internalize adult standards in this manner and attempt to regulate our own behavior and react with positive or negative feelings about self at the perceived evaluations/reactions of significant adults (Kaplan, 1976).

Kaplan (1976) further noted that low self-esteem is thought to be caused by individuals' self-perceptions that either their behavior or characteristics do not meet personal standards valued by the social system; by self-perceptions that significant others do not value them positively or perhaps even value them negatively; or that they might not have developed "normatively acceptable coping mechanisms" that could pro-

tect them from the effect of "self-perceptions of failure or rejection by others" (p.790). Someone with a history of being devalued will most likely have low self-esteem. This can be said to evolve from two sources: first, an individual's history of negative self-evaluation and perception, and, second, perceptions of highly valued others in the environment responding to the individual with less than positive attitudes (Kaplan, 1975). An individual is more likely to value the attitudes of those persons "who were associated with need gratification or deprivation" (p.37).

Psychological Influences on Self-Esteem

Psychological determinants of self-esteem refer mostly to the type of defense mechanisms an individual can develop to cushion negative feedback or self-perceptions of being negatively evaluated or rejected. Protection of self-esteem is a primary developmental task of children (Mack & Ablon, 1983). These authors further maintain that it is "questionable indeed, whether human beings can deeply experience positive self-worth except as the result of a relationship" (p. 9). Everyone knows two basic truths about the self. The first is that the self is alone and private, and the other is "that one is a real self only to the extent that caring and reaching beyond the self continue" (Yankelovich, 1981, p. 240). Therefore, the second psychological determinant of self-esteem is one's feelings about the level of success within relationships.

The whole notion of connectedness or belonging to someone is central to the development of self-esteem. Belonging to a family, a culture, a community, or a school provides a connection to sustain a sense of worth. Lacking such a feeling, one is likely to feel not valued, or not of value, and retreat into a defensive posture to avoid the pain of feeling isolated, hopeless, worthless, and unconnected. "Virtually all maladaptive defensive patterns in childhood, adolescence, and adult life have as at least one major purpose, protection of the pain associated with lowered self-esteem" (Mack & Albon, 1983, p.38).

Physical Influences on Self-Esteem

Inherited physical characteristics such as physique, appearance, and handicaps also may influence self-esteem. The physical attributes an individual has inherited can affect others' perceptions and behavior. Others may respond negatively to an individual's handicapping condition or physical appearance, thus affecting that individual's self-esteem, even though the individual's initial self-perception may not have been negative.

Others' reactions to self are also influenced by maturation rates. Adults treat children differently at different maturation levels. Children who mature early are often treated as adults and develop positive self-esteem. On the other hand, those who mature later and continue to be treated as children tend to develop low self-esteem. Even when this latter group matures, they often maintain old self-perceptions and the corresponding low self-esteem. Maturation also affects mastery of developmental tasks. Social disapproval, maladjustment, and increased difficulty in mastering higher level developmental tasks are all possible results of delayed maturation (Frey & Carlock, 1984).

Environmental Influences on Self-Esteem

It is difficult to define the effect that environment plays in the development of low self-esteem. A person learns values and satisfies needs within the environment through social interaction with significant others. If needs are not met and a person's expression of beliefs and values meets with disapproval within the environment, self-esteem will likely be damaged.

An additional aspect of environmental influences has to do with the groups within the environment with which the person identifies. Each member of a group is evaluated by every other member. If the group is significant to an individual, these evaluations will affect self-esteem. For example, if a person's perception is one of not being valued by the group, low self-esteem is probable. Esteem is related to one's rank in a group rather than the rank of the group when compared to other groups (Rosenberg, 1965).

Cultural Influences on Self-Esteem

Self-esteem is also affected by the extent of one's identity with a broader group, a cultural or national group. If the culture or nation is not esteemed by other cultures or nations, those identifying with those cultures or nations may suffer low self-esteem. We see this occurring with minorities when they experience difficulty assimilating another culture's values.

Difficulties arise when minorities identify with their own culture, are accepted and develop positive feelings of worth within that culture, and then try "to make it" in another culture. This is particularly painful when the culture of origin does not seem to be valued in the new culture and the beliefs and values of the two cultures are divergent.

All of the above factors—parental, social, psychological, physical, environmental, and cultural—contribute to the development of self-

esteem to the extent that each or all of these are valued or devalued by significant others who provide feedback. This feedback is both verbal and nonverbal, overt and covert, and dramatically affects how adolescents see themselves.

The Intervention Process

Frey and Carlock (1984) identified four phases in the process of intervention to build self-esteem: (1) identity; (2) strengths and weaknesses; (3) nurturing; and (4) maintenance.

The goal of the first phase of intervention, identity, is to help the individual gain knowledge and understanding of self. The authors caution about beginning anywhere else. Many helpers begin at a more advanced state and find their subjects unable to begin. Those with low self-esteem tend to focus on the parts of self that are negative. They find it difficult to focus on strengths because they tend to see little if anything positive about themselves. Furthermore, attempts to first intervene at the nurturing or maintenance phase meet with failure because individuals with low self-esteem see very little if anything about themselves that might be nurtured or maintained. Nurturing may be what the helper thinks they need; however, if they have low self-esteem, chances are this is a skill they have not mastered.

The identity phase is vital because it enables individuals with low self-esteem to become aware of themselves in a less lopsided or more balanced fashion. Helpers often omit this phase. It is important to be aware that entering the intervention process at this phase breaks down barriers and sets the stage for empowering individuals to sustain high levels of self-esteem, which is the ultimate goal of intervention.

Once the person with low self-esteem has a broad awareness of self, it is easier to move into phase two and recognize strengths and weaknesses. Individuals can examine or reexamine aspects of self and see them from a different perspective. Others can help in this process by providing specific, nonjudgmental feedback about positive and negative traits. The key is to provide this feedback in a five-to-one ratio, positive to negative, for optimal effect (Frey & Carlock, 1984).

Those receiving feedback must be taught to accept only what is true about themselves. Feedback refers to others' perceptions of behavior and is colored by their beliefs, values, attitudes, methods of expression, and self-esteem issues. It is important to teach screening skills so appropriate feedback can be absorbed. Individuals with low self-esteem tend either to accept all feedback or to deny it all. The screening process

helps them establish information that is true and information that is a projection from the giver.

After identifying strengths and weaknesses, the third phase of intervention is learning ways to sustain the growth in self-esteem through nurturance. Learning to nourish or nurture oneself is a process of learning how to fill needs, how to change attitudes and perceptions that become self-fulfilling prophecies, how to give and get support or set up support systems, and how to find ways to enhance one's positive self-perception.

A final phase in the process of building self-esteem is that of learning how to maintain acceptable levels of self-esteem. This phase entails: (1) developing skills to change perspectives; (2) practicing risk taking; (3) learning new skills to ensure success experiences; and (4) identifying realistic goals and outcomes. Building self-esteem is an evolving process with the ultimate goal of sustaining high levels of self-esteem. Learning ways to enhance self-esteem becomes a lifetime project!

Activities and Strategies to Build Self-Esteem

Many resources are available that describe activities to enhance self-esteem. Examples of activities are provided for use at each step in the process. Readers are encouraged to use additional resources for more activities.

Phase One—Identity

Any activities that focus on the individual's self-awareness are appropriate at this stage. Awareness of feelings and thoughts about family and self are appropriate here. Many centering and imagery activities also are appropriate. Some examples are:

Values exercises—values clarification by Simon, Leland, Howe, and Kirschenbaum (1978) is a valuable tool to help adolescents identify what they believe. These structured exercises (see the two examples below) can be used with a group or with individuals.

What's in your wallet? (Strategy number 63, p. 329) This values exercise provides the opportunity to learn about what is valued through noting what we carry with us daily. Participants are instructed to pull out three articles they carry with them in their wallet (or purse). Individuals are then given the opportunity to talk about the importance of these articles in their life.

Personal coat of arms. (Strategy number 47, p. 278) Individuals are instructed to create their own coat of arms that will depict several aspects of self. Participants draw a coat of arms (or are given an outline

of one), and divide it into segments corresponding to the number of topics to be covered. Some suggestions are to identify: (1) your greatest personal achievement, (2) your family's greatest achievement, (3) your greatest personal failure, (4) three things you would like to have said about you if you died today, (5) your personal motto, and (6) one thing you would like to accomplish by age 65. Further suggestions are included.

Polarities (Frey & Carlock, 1984, p. 117). Participants identify five qualities that describe themselves, and indicate the opposites of each of the qualities. They are then asked how they are able to own both sides. In groups of three or four, they spend 3 minutes acting out one side, then 3 minutes acting out the other side. Full group discussion centers around accepting the qualities that were listed as opposites, or the side of ourselves we disown, the "dark side." Participants also identify situations where some of these "dark side" qualities could be a help and then situations where some of the qualities listed first could be a problem.

Who am I? This activity has several variations. Frey and Carlock (1984, p. 122) suggest an individual think about the question "Who am I?" and identify a list of 100 or more responses, trying not to censor. Processing centers around themes and any omission of key areas such as spiritual, social, physical, intellectual, or emotional areas.

Another version is to have individuals think of the roles they play in daily life such as student, friend, brother, worker, sister, niece, and rank the 10 roles from 1 (most important) to 10 (least important). In the processing that follows, each person talks about what it would be like if the role were relinquished.

Trust exercises. Learning to trust self and others is an aspect of the identity phase that should be included. There are a variety of such exercises.

In the *trust walk* or *blind walk* (Stevens, 1971, p. 207), each person has a partner. In each pair one becomes a "blind" person and the other becomes the leader who is responsible for showing the blind person what the world is like. Later partners change roles.

The *trust fall* (Stevens, 1971, p. 263) can be done in a small group or with two people. In a small circle, one person (whose eyes are closed, hands and arms either clasped or hanging loosely at the side) falls backwards and is caught and gently passed around the circle. The circle begins with members close together and gradually spreads out during the exercise. The person is caught and gently returned to a standing position. A variation for this (Weinstein & Goodman, 1980, p. 46) is to have two people stand about 2 feet away from each other with palms out at chest level, facing each other. As they fall forward they catch

themselves on the partner's hands, push off, take a step backward and fall forward again. They continue this process as long as they can safely do so.

Imagery exercises. The following exercises also are helpful in the identity phase.

Dreams of the future (Reasoner, 1982, p. 38, #6) requires adolescents to visualize the kind of person they would like to become, how they would like to be seen by others, skills they would like to have in the future, and so forth.

Treasure map (Gawain, 1982, pp. 11–12) is an actual, physical picture of a person's desired reality. This can be done by painting, drawing, or using pictures and words from magazines or photographs. The focus is on a particular goal or area of the individual's life and depicts the ideal situation, completed, as if it were already true. The person creating the treasure map must be sure to be included either in a drawing or by a photograph. The individual's image must be shown doing or having the desired objective. Make the setting real and believable and include affirmations. Gawain believes that the cosmic affirmation must also be included, "This or something better now manifests for me in totally satisfying and harmonious ways for the highest good of all concerned" (p. 12).

Additional imagery exercises can be located in *Awareness* by John O. Stevens (1971). Stevens's exercises are excellent and still very usable now. Gawain's *The Creative Visualization Workbook* (1982) is also helpful.

Phase Two—Strengths and Weaknesses

As individuals become more aware of themselves and become more comfortable with focusing on self and personal discussions, they will be better able to discuss strengths and weaknesses. It is important in this stage to provide information about giving and receiving feedback. Basically feedback should be phrased in behavioral terms and with no evaluative judgments. For example, "I was pleased when you remembered my birthday" is more specific than "You're a great person." Similarly, it is important to be able to filter feedback. Individuals must learn to filter out what is appropriate and what is not.

Managing your pig (Frey & Carlock, 1984, p. 127). This is an activity in which individuals can discover parts of themselves that they criticize or dislike. They can learn methods for changing or stopping these negative messages. Participants are asked to make a list of "things I get down on myself about" (p. 127). They identify their level of willingness to change each behavior according to a five-point scale, (a) "I am not ready to change this yet"; (b) "I am working on this one step at

a time"; (c) "I want to work on this in the future"; (d) "I am confused about what I want to do about this"; and, (e) "I am working hard to change this" (p. 128). During this activity, participants set goals for change and assess the reality of these plans.

The following are variations for identifying strengths and are found in many sources. Some of the more specific sources are identified.

Personal descriptions. Each person in a group writes a description about another person, describing only positive aspects. These are placed in a hat, and each person chooses one description and reads it with everyone guessing whom it describes.

In another variation, called *stroke sheet* (Frey & Carlock, 1984, p. 129), participants have a sheet of paper pinned to their back, and everyone walks around and writes positive statements, words, phrases (strokes) on these papers, which are later read in the group.

Bombardment (Reasoner, 1982, p. 31). A 3 × 5-inch card, one for each group member, is passed around the group, and group members are instructed to write something positive about every other member. Group members receive their cards and can choose to read any or all of them aloud. A variation used by the author allows each individual to describe personal strengths for 3 minutes and then allows group members to contribute what they see as this person's strengths for 2 additional minutes. This variation is best used with a group that has already spent time together.

Slams and strokes (called "sticks and stones" by Frey & Carlock, 1984, p. 128) enables each person to provide feedback to another by relating something negative followed by something positive. One person volunteers to throw the "sticks and stones" (words) tailored to the groups' characteristics, designed to drag people down. After each statement, the group responds "It doesn't matter what you say, I'm still a good person. I'm OK" (p. 129). The response gets louder and more convincing as the insults continue. Processing must include feelings about being the one doing the insulting, as well as feelings about being insulted. This can also lead to discussion about useful processes for filtering negative communication.

Phase Three—Nurturing

Nurturing activities are designed to teach individuals how to nourish themselves and others. Once an individual has identified strengths and weaknesses and developed new awarenesses, it is important to continue the growth, like tending a new flower. Some positive feelings come from reinforcing strengths in self and some come from reinforcing strengths in others. As a person's self-esteem grows, weaknesses are minimized

and strengths are emphasized. This is the purpose of the following activities:

Giving gifts (Author). The group can be any size and should be standing in a circle. One person volunteers to stand in the center with eyes closed. Other members of the group give the person in the center "gifts" such as hugs, a pat on the back, or a backrub. The person receiving these gifts cannot respond. Processing includes discussing both receiving and giving these "gifts."

Standing ovations (Weinstein & Goodman, 1980). Everyone feels good after a standing ovation! This activity can be used in any situation or group. The rule is very simple—if someone wants a standing ovation, that person says, "I want a standing ovation!" Others in the group provide the standing ovation. A variation is to structure the activity to have people disclose something about which they feel proud and then ask for a standing ovation.

I appreciate what you did today. You . . . (Reasoner, 1982, p. 31). This activity focuses on noticing pleasing actions people take toward each other, and allows the recipient to provide written, specific feedback about what that action was. The recipient writes a note to the person who did the deed saying, "I appreciate what you did today. You . . . ", completes the description, and gives it to the doer.

Mascot (Dusa, 1983). Choose a group mascot, name it, and have an adolescent hold it as a signal to others that he or she is having a bad day and needs nurturing. The mascot can be a stuffed animal, a book, or whatever the group chooses.

Relaxation imagery: The power of the mind (Frey & Carlock, 1984, p. 228). Participants rate their current degree of tension-relaxation from 0–100, 0 being the most relaxed and 100 being the most tense. They then create a list of things that are relaxing to them and a list of things they do well (competencies). Through a process of visualizing a relaxing scene, with as much detail as possible, alternating with items from the "competency list," participants learn how visualizing can affect mood and levels of tension and relaxation.

Lifting and rocking (Stevens, 1971, p. 266). In a small group of seven to nine people, one person lies on the floor and the others support and lift the individual, using a gentle rocking motion, and then slowly lower that person to the floor. Activity is nonverbal, but soft music can be used.

Phase Four—Maintenance

The maintenance phase entails learning ways to sustain acceptable levels of self-esteem. During this period activities involve goal setting,

assertiveness training, risk taking, and learning the skills necessary to fulfill needs.

Building a support system (Authors). Individuals divide a sheet of paper into four squares and label each as one of the following—listening, emotional support, emotional challenge, and reality check. Everyone on the list should be someone whom the individual trusts and who is nonjudgmental. Listeners listen, emotional supporters provide perceived support (mothers can be listed here), emotional challengers encourage the individual to stretch, question, confront, and challenge, and those in the reality check category provide confirmation of reality. First, individuals fill in each square with names of people available to them in each category. Next, participants list people who are possibilities to be included in an area and, finally, list the barriers to having these possible supporters actually become a functioning segment of the support system. There are two more categories that can be added. Technical supporters are those who know an individual's job and can provide feedback, and technical challengers are those who encourage a person to stretch, question, confront, and challenge in the technical/professional area. Discussion includes scrutinizing the barriers to see whose barriers they are. This activity can be followed with a planning and goal-setting activity to actively eliminate the barriers and incorporate any or all of those "possibilities" into supporters who are present for the individual.

Write a letter to yourself (Frey & Carlock, 1984, p. 140). Participants write themselves letters describing what they have learned about themselves, what they are concerned with about themselves, what they really like about themselves, and what they wonder about themselves. They then give the letter to someone who will mail it back to them a couple of months later.

Any special seminars or workshops that provide skills training would be helpful during this period. Specific information about communication (verbal and nonverbal); introducing the idea of group rules; helping adolescents and parents develop parental support; computer training; career programs; mentorship programs for peer, male, female, and minority adolescents; and problem-solving and conflict-resolution activities all help an individual to maintain appropriate levels of self-esteem. Additional activities might include a variety of human potential seminars on building skills such as study skills, library use skills, math skills, and relationship building skills.

The activities mentioned are samples of the types of activities that are available in those sources identified as well as in other books on self-esteem.

Case Study of a Success Program

A recent program piloted in Washington State serves as the basis for this case study. The program, called the Integrated Learning Model (Crow & McKisson, 1985), focuses on integrating career development and learning through a program that provides "connectedness" for those at-risk adolescents involved. The program's developers, Crow and McKisson, describe the program as a powerful experience for the adults involved as well as for the adolescents.

Motivation to develop this curriculum stemmed from experiences both authors had with inmates at local correctional institutions. As this population went through a program about the workplace, career issues, and learning styles, comments such as "I never thought I could learn. I was always dumb"; "I never thought of having a career—I never have seen myself as part of the workplace" were made.

Most of the participants in these classes disclosed that in one way or another they had always seen themselves as losers. Sometimes these messages came from family sources and sometimes from school as they received information about how they operated in the world. Because self-esteem is an individual's evaluation of self-worth based on information received from successes and failures and on information received from others, it could be suspected that these individuals have low self-esteem.

As a result of these experiences, Crow and McKisson (1985) developed the Integrated Learning Model. The program consists of four components: learning and thinking, career development, basic skills, and interpersonal and social skills. These four components are not separate but integrated into a curriculum. For example, the career development class has been built around learning styles and includes activities to promote learning of interpersonal and social skills. In all classes, a primary focus was to help the adolescents find their "gifts."

The following paragraphs describe the most recent program:

Participants

Forty three 14- and 15-year-olds were referred by school counselors, teachers, and in some cases, parents. The adolescents were referred for a variety of reasons, including low self-esteem, low achievement, withdrawal/isolation from people, truancy, or trouble with the law. Joan and Andy, the two adolescents mentioned at the beginning of this chapter, were members of this group.

Faculty

Four faculty members taught the four components, and four teachers were assigned 10 to 12 adolescents to follow for the 4 days at the camp. The teachers attended classes with the adolescents and were involved in all the activities. They monitored their group, debriefed them each evening, and provided support. They also served as local resources for the four faculty members. The adolescents stayed in cabins with a peer-age counselor. During the debriefing when the adolescents brought up instances of an activity they disliked, the teachers responded nonjudgmentally with questions like: "What is there about that activity that bothered you?" "Where did that come from?" "Does everyone feel that way?" For example, during the stay there were many activities where adolescents had to hold hands. In a subsequent debriefing session, one of the boys said that he did not like that particular activity. The response was, "What was it about the activity that you disliked?" The answer was, "Because boys had to hold hands." "Where did that come from?" led to a more general discussion of how everyone felt. The result of the conversation was that each person was heard, and they discovered that everyone did not agree. This opened the way for alternative ways of thinking about the issue.

Program

Adolescents attended four classes over the 4 days: finding your gift, learning to learn, the future workplace, and thinking. There were many activities in which all were involved. One was an experience called Ropes (described later). There were two underlying goals in all these classes and activities: (1) to help each participant focus on personal gifts, and (2) to enable each participant to make connections with others.

Opening night (identity phase). Icebreakers were designed to help individuals make contact with each other and begin to focus on gifts. For example, each person had to fill out a bingo card with 20 squares containing 20 different descriptions such as "I am left-handed," "I am good at sports," "I like to write," "I like movies," "I am a good cook." They moved around the room finding a person to fit the description in each square and asked that person to sign the square. They progressed to Bolles Party Game, in which people move into different groups based on their interests and discuss what they do that brought them to a particular group. Through this process, in which they move two more times to second- and third-choice groups, the group began to focus on gifts.

This first evening participants also took the Kolb-McCarthy Learning Style Inventory. They were divided into four groups according to the

results for further discussion of their learning styles. This too was used during the camp to help them focus on their gifts and to encourage them to "stretch." Individuals were introduced to the concept of a standing ovation discussed previously.

Finding your gifts (strengths and weaknesses, nurturing, maintenance). This class had individuals complete activities where they identified strengths, skills, talents, and areas that were a "stretch" for them. They studied goal setting by going through a process of identifying challenges as "mountains to climb" and areas in which they were actively trying to improve. Through creating their own metaphors to describe themselves, they related their gifts to these metaphors and planned strategies to share their gifts.

Thinking (maintenance). This class combined creativity with problem solving, decision making, conflict resolution, risking, and job hunting to address many of the issues adolescents face. The activities encouraged the individuals to be creative to solve a problem and to look at other possibilities.

Learning to learn (identity, strengths and weaknesses, maintenance). Many adolescents identified as being at-risk have difficulty with schoolwork, so this class concentrated on strategies of learning. Discussions helped the individuals understand how they learn best, what excites them about learning, and what turns them off. Improving memory, test-taking techniques, note taking, asking questions, solving special test questions, and perceptions were all tools for learning that were taught in this class.

The future workplace, gifts applied (identity, strengths and weaknesses, nurturing, maintenance). This class described what all individuals should know about the workplace and helped them look at their gifts and think how these gifts would transfer to the workplace. They also became aware of the skills everyone will need in order to find or create a place for themselves in the workplace.

Ropes activity/class (identity, strengths and weaknesses, nurturing, maintenance). The theme of this class was teamwork. Each team was made up of 10 to 12 members, including some adult staff. The team was taken through a course out-of-doors, and as they encountered an obstacle, the teacher/leader described the dangers and the goal. The team decided as a group how they would successfully overcome the obstacle and reach the desired goal.

Trust exercises were initiated to develop team trust, and then the teams approached the first obstacle. The following are some examples of the "obstacles":

The individuals were told they were in a hot desert and they had to move to a cooler place. They could not, however, walk on the ground.

Their only mode of transportation was two 2' × 4's lying on the ground, with several pieces of knotted rope threaded through holes in the boards. As a team, they had to decide how to "save themselves."

As they walked through the woods, they came upon a large revolving spool suspended between two trees, blocking the path through which they had to pass. Their task was to decide how they would get to the other side of the revolving spool without touching the ground.

Then they came to a shallow creek. They were told the brook contained piranhas, so their feet could not touch the water. A large tree limb with a long rope attached to it extended over the brook. Obviously each member of the team had to swing over the brook. The problem was to get the rope within reach so they could move to the other side.

Each of these "obstacles" required everyone to work together both to decide upon a solution and to carry it out. It involved trust, risking, and new challenges for many participants. The course was created "to promote cooperative problem solving and to enhance self-concepts through an interesting series of carefully planned physical and mental challenges." All groups were closely supervised (Crow & McKisson, 1985, p. 1).

Hiking (nurturing). Participants hiked 2½ miles up a mountain where they could view Mt. St. Helens and Crater Lake. Evening activities included campfires, skits, and activities that encouraged individuals to challenge themselves and learn more about their greatness (identity, strengths and weaknesses, nurturance).

The faculty's assessment was that the individuals generally regarded the first night's exercises with some reserve. The first group went through the Ropes Course the next morning, and the change in the group after completing the 3-hour experience was marked. This transformation was evident in each subsequent group. The process of working together, each member contributing to the successful completion of the tasks, brought participants closer together.

The faculty saw the participants make connections with each other. As they worked together and learned together, some of their barriers came down. The "Friendship Circle" (nurturing) on the last night found all individuals more open about their feelings, although some participants retained some of their initial reserve. The emotions expressed that night demonstrated to the staff that bonds had been established.

Faculty observers reflected on their feelings about the success of the 4-day experience. They saw individuals become more open, more willing to risk, and much more positive about what they each had to offer others. They saw them helping each other, sharing, believing in themselves, emerging as leaders, and often surprising themselves. One faculty member described the experience as "powerful" for both the adolescents and faculty.

The real evaluation came from the participants. Some selected comments in response to the question, "What have you learned?" follow: "I learned confidence in myself; I learned that I have lots of talents; I learned I can voice my opinion"; "I learned that I was a leader and how to improve myself in school and in work"; "The teachers are great, and if you do something wrong, they still treat you like a person"; "That I'm just as good as anybody else, and when I get afraid don't keep it in, go to a friend or someone for help, that there is a place for me in the world"; "That I could trust other people"; "That I can get along with others better than I thought"; "I learned that there is caring and nice people, how to trust and work with others. I also learned that it's hard leaving the ones you love and care about!"; "I have more confidence and more courage"; "I'm nice and helpful. I have some stupid problems. I'm worth something"; "You find out you're not the only person with problems. You feel better about yourself and what you can do"; "I didn't know so many people could care."

Joan was one of the adolescents who emerged as a leader during the experience. She organized other persons into work details and later told staff members, "I gained confidence in myself!" She told them that she had discovered that other "kids" liked her and that she had gifts to offer others. She was excited about applying her newly acquired knowledge about herself at school and was optimistic about her next year in school.

Andy kept to himself during many of the activities. He participated sporadically and usually could be found on the fringes of the group, listening quietly. Occasionally he would make a contribution and then withdraw. The last evening at the final event he left to go for a walk. Others noticed he was missing and went looking for him. When they finally found him, they expressed their genuine concern for him. When the group returned, Andy went to a staff member and in a surprised voice said, "They were really worried about me!" Though he wasn't observed talking with those in the group who found him, he did "hang out" with them for the rest of the evening. However, the next morning when he appeared for the trip home, he seemed withdrawn once more. He said goodbye and told a staff member that the experience was "okay."

A young lady preparing to leave the camp got off the bus several times to make the rounds and hug everyone. The group leaving the camp was a different group than the one that had arrived 4 days earlier.

Conclusions

In our society, young people exhibit deviant behaviors daily. There is evidence that many adolescents demonstrate at-risk characteristics.

These young people are considered to be at risk because, unless they are helped to succeed, they too will become part of the deviant subculture. Research has shown that there is a connection between how one feels about oneself and how one acts (Kaplan, Martin, & Johnson, 1986; Kaplan, 1975; Marston, Jacobs, Singer, Widaman, & Little, 1988). Low self-esteem is an issue that must be confronted as a cause of at-risk behaviors.

This chapter has identified specific symptoms of low self-esteem, factors that influence self-esteem, and an intervention process. The activities designed to be used with adolescents are not extensive, and readers are encouraged to collect and create their own. The goal is to reach all adolescents, particularly those who are at risk, and to give them a chance to succeed. The Joans and Andys need guidance and support.

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Chapter 6

WHEN LIFE SEEMS DARKEST: ADOLESCENT DEPRESSION

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Introduction and Problem Statement

The incidence and nature of depression during adolescence are controversial topics (Esman, 1982; Oldham, 1978). Historically grounded in traditional psychoanalytic theory, depression is a manifestation of conflict between the ego and superego. Yet, neither of these components are thought to be fully present before late adolescence (Garrison, Shoenbach, & Kaplan, 1985). As a result of this model, mental health researchers and practitioners for decades discounted the existence of depressive disorders during childhood and early adolescence. Nevertheless, adolescent depression is a significant phenomenon and deserves full attention.

In this chapter, we will present a variety of perspectives that address the symptoms, causes, and treatments of adolescent depression. After briefly discussing some research related to depressive disorders among adolescents, we will describe the case of Stacy, an adolescent who is struggling with depression, and use her situation as a means of presenting some of the causal models and related intervention strategies for this disorder. Finally, after describing these various strategies, we will advocate a purposefully eclectic and comprehensive treatment intervention designed to grapple with Stacy's depression from several points of view.

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Review of Related Literature

Aspects of adolescent depression have been greatly influenced by psychoanalytic theory. For example, an important aspect of psychoanalytic theory is the concept of "adolescent turmoil." According to this conceptualization, all adolescents go through a period of developmental turmoil that may seem to be psychopathological. Behavior is attributed to a naturally occurring ego regression. Personality upheaval, inner unrest, and deviant behavior are considered normative expressions during the developmental period. As a result, the significance of depressive symptoms is minimized. These symptoms are thought to be a normal part of adolescence and, therefore, clinically unimportant (Garrison et al., 1985). In fact, as Robbins and Kashani (1986) suggested, clinicians who adhere to this perspective consider the absence of symptoms of adolescent turmoil to be pathological. Thus, due to the predominance of the psychoanalytic model of depression, childhood and early adolescent depression were discounted, and depression in late adolescence was ignored.

Some research refutes the concept of "adolescent turmoil" as a specific characteristic of adolescence (Rutter, Graham, Chadwick, & Yule, 1976). Indeed, Weiner (1975) concluded that no common picture of adolescent turmoil exists; that there is no consistent period of difficult psychological adjustment that adolescents outgrow, and that similar behavioral manifestations may be found in adult populations. It has been further suggested that many adolescent problems or maladjustments are not transitory but may lead to significant disturbances in adulthood (Garrison et al., 1985). Over the past 2 decades, there has been a resurgence of research attending to the prevalence of depression in all age groups. However, our understanding of adolescent and childhood depression has been retarded by the concept of "masked depression," which received growing support during the 1960s. This model suggests that, although depression is experienced in childhood and adolescence, it is not manifested as such. It is, instead, masked by other behaviors or symptoms not usually thought to be depression, such as irritability and hyperactivity, aggressiveness and delinquency, somatic complaints and hypochondriasis, anorexia nervosa, obesity, poor school performance, school phobia, loss of initiative, social withdrawal, and sleep difficulties (Carlson, 1981; Carlson & Cantwell, 1980; Davis, 1983; Husain & Vandiver, 1984).

Although frequently utilized in the literature, the concept of masked depression is difficult to validate, is controversial, and has been refuted in research (Carlson & Cantwell, 1980; Cytryn, McKnew, & Bunney,

1980; Kovacs & Beck, 1977). For example, Kovacs and Beck concluded that "masking behaviors" are better conceptualized as presenting complaints. Carlson and Cantwell suggested that these complaints may meet criteria for other disorders, such as behavior disorders, but to the astute clinician depression will be identified and, therefore, unmasked. Cytryn et al. (1980) further caution that, when making a primary diagnosis, practitioners should determine whether the depressive equivalents or the depressive symptoms dominate within the client.

The criticisms for both the masked depression model and the concept of adolescent turmoil as explanations for depressive symptomatology have led to current acceptance in the research literature that depression exists across all age groups (Carlson & Cantwell, 1980; Cytryn et al., 1980; Puig-Antich, 1982; Reynolds, 1984). This general agreement about the presence of depression in adolescence has led to the opinion that adult diagnostic criteria can be useful for both adolescents and children (Reynolds, 1984). Given this consensus, it is appropriate to further describe the procedures for the diagnosis of depression among adolescent populations.

For the last 3 decades, the classification system most widely used has been the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*. The revised, third edition of the manual, referred to hereafter as the DSM-III-R, was published in 1987. The DSM-III-R system of classification helps to ameliorate the problems and controversies associated with general classification concepts such as "adolescent turmoil" and "masked depression." The DSM-III-R does this by providing a description of the diagnostic categories of depression without projecting specific philosophical orientations or debating specific arguments regarding depression classification (Levitt, Lubin, & Brooks, 1983; Coyne, 1986).

The DSM-III-R classifies depression into two categories. The first category is "Major Affective Disorder," which includes two subcategories, Major Depression and Bipolar Disorder. Both describe the presence of a full syndrome of depression. However, the major distinction between the two is that Bipolar Disorder includes the manifestation of a manic episode. The second category is "Other Specific Affective Disorders," which could indicate either a Cyclothymic (mild bipolar) Disorder or a Dysthymic Disorder, which are both conditions indicating that mood disturbance has been chronic or intermittent for at least 2 years, but without the degree of severity to warrant a diagnosis of Major Affective Disorder. A third category, "Atypical Affective Disorders," provides subcategories for those affective disorders that cannot be classified under either of the two previous categories. This includes Atypical Bipolar Disorder and Atypical Depression. Given this system of classification,

it is evident that the identification and definition of depression can indeed be a complicated procedure. Nevertheless, the DSM-III-R is useful to the counselor and psychologist in that it provides a systematic vocabulary and consistent framework for conceptualizing and categorizing mental disorders including depression.

The DSM-III-R is widely used by researchers and clinicians for diagnostic classification of depression and is used in most clinical settings. It is considered a valid and useful system for diagnosing both child and adolescent depression (Cytryn et al., 1980; Pfeffer, 1986; Reynolds, 1984; Robbins & Kashani, 1986; Weiner, 1983). Furthermore, although the DSM-III-R describes some age-specific features of depression, it suggests that affective disorders are consistent across all age groups.

Even though current diagnostic criteria, such as those provided by the DSM-III-R, support the perspective that depression exists among all age groups, adolescent depression is still relatively neglected in the research literature (Kandel & Davies, 1982; Poznanski, 1984). Studies that do exist vary greatly in their definition of depression and in the methods utilized to determine the presence and severity of depression among adolescents. Because of these problems, the incidence of adolescent depression varies significantly across studies. Among adolescent clinical populations, for example, estimates of depression range from 3% to 33% (Albert & Beck, 1975; Robbins, Alessi, Cook, Poznanski, & Yanchyshyn, 1982). Despite limited and methodologically weak research regarding depression in normal adolescent populations, there is considerable indication that adolescent depression is a significant problem (Garrison et al., 1985). For example, Reynolds (1983) reported that 34% of a large sample of high school students were at least mildly depressed.

In addition to some of the problems mentioned above, research in adolescent depression lags behind other areas because of major flaws in methodology. These tend to fall into three categories. The first is a problem of sampling differences. Most research is based on "samples of convenience," that is, subjects who are in various treatment settings, rather than normative populations. Similarly, the age of subjects varies greatly across studies, limiting the generalizability of findings to the normal population (Reynolds, 1985). Second, variations in assessment techniques or in the cutoff scores for levels of depression, when the same measures are used, severely limit the standardization of depression assessment. Finally, there has been ambiguity regarding the diagnostic criteria for adolescent depression. With only recent acceptance of the DSM-III-R system for diagnosing child and adolescent depression, concurrent with the diagnostic distinction between depression as a symptom

versus depression as a syndrome, disparate rates of incidence among studies should not be surprising.

Causes and Treatments of Depression

A number of etiological and conceptual models of depression and related treatment strategies have been developed. The following sections of this chapter deal with these models of adolescent depression and provide various related treatment approaches. To explain these models and their treatment implications, we would like to present the case of Stacy. This case study will make it possible to discuss the practical and applied components of each model.

The Case of Stacy

Descriptive information. Stacy is a 15-year-old Caucasian girl and the only child of parents who are both teachers. Stacy's father, John, is a vocational education teacher at a community college and Stacy's mother, Theresa, is an elementary school teacher. The family lives comfortably in a middle-income neighborhood. Stacy is a shy, overweight youngster who is suspected of having a moderate reading disability (dyslexia). Stacy also has a slight speech impediment.

Background information. Stacy was an unplanned baby and her parents were ambivalent whether or not to have her. Stacy's mother took an extended leave of absence from her teaching career to take care of the baby. Stacy and her mother became very attached. As Stacy developed, her milestones became progressively delayed, but not out of the "normal" range for her age. Stacy was a sickly child and was a frequent patient at the family physician's office. Stacy is fearful of strangers—a trait she has exhibited since infancy. Stacy and her mom usually spent their days together until Stacy began preschool at age 4. Stacy had a great deal of difficulty beginning preschool. Her mother had to stay with her in the school for the first 2 weeks. Each day, Stacy would cry and refuse to go to school. Her "school phobia" continued throughout her early school years. Even now, Stacy often complains of illnesses to avoid school. She is fearful of new situations, preferring the safety of her family and familiar experiences. Her teachers describe her as an anxious, bashful, withdrawn youngster with few, if any, friends. Whereas many of Stacy's classmates are highly interested in peers and have developed solid patterns of peer relationships, she is becoming more isolated and withdrawn because she prefers her parents' company to participating in age-appropriate social events.

Parenting style. Stacy's mother, Theresa, is an anxious, emotionally volatile woman. Records indicate that she was overly solicitous of Stacy in earlier years. However, as Stacy has become an adolescent, her mood toward Stacy alternates between a detached disinterest and feelings of guilt at her inability to feel a strong sense of involvement in her daughter's life. When Stacy was young she would try new behaviors, but Theresa would not respond in any expressive way toward these attempts. Theresa also continues to be resentful of her career interruption and her husband's lack of involvement with Stacy. John spends long hours at the shop, teaching additional classes several nights a week, and avoids taking much responsibility for Stacy's discipline or encouragement. When Stacy's parents discipline her, they tend to scold and nag her to do better in school or to quit whining like a young child. There is little investment in actual behavior change. Both parents have attempted to "push" Stacy into school activities and age-appropriate relationships, but these attempts resulted in frustration and hopelessness. Stacy's parents believe they have tried everything to stimulate Stacy's interest in activities outside the family but they have failed in their attempts.

Resulting problems. Stacy's withdrawing, shy nature has become exaggerated recently. She has become the butt of some cruel comments about her weight and speech problems. Stacy's schoolwork has begun to suffer; she often does not complete or turn in assignments, listen to instructions, or use her time efficiently. Recently, a school counselor found Stacy hiding in the girl's restroom, crying and talking to herself as if she were a young child. Apparently, she had awakened that morning to find that her cat had run away. Upon coming to school, two girl classmates began to tease and to taunt her and she ran into the bathroom to hide. She expressed considerable gloom and despair to the counselor, stating frequently, "I'm no good." "I'm rotten." "Things will never get better." "There's nothing I can do."

Comprehensive Treatment Intervention

The case of Stacy presents a rather complex pattern of cognition, behavior, affect, and family structure, all of which undoubtedly contribute to Stacy's presenting problems. To determine the nature and severity of Stacy's apparent anxiety and depression, thorough assessment procedures, including a family intake, measures of anxiety and of depression, and clinical judgment should be utilized. It is obvious that Stacy suffers from deficient self-esteem along with depression, which is nearly always the case. This is a result of, and at the same time a contributing factor to, the family dynamics, poor school performance, fear of inter-

action within the school milieu, and peer rejection. Perhaps as much as any other emotional problem, depression is influenced by and influences other aspects of life.

Given the complexity of Stacy's development and family environment and in order to effectively treat the symptomatology of depression that Stacy exhibits, a comprehensive, multidimensional treatment strategy needs to be employed. The following plans are suggested for Stacy because they attend to her presenting complaints. Although the approaches may be altered or modified given more specific information regarding Stacy, the following models seem to provide appropriate strategies for an adolescent in her current situation. They are based on the belief that psychologists, counselors, and other mental health workers need a "working hypothesis" of the problem that is based on both the case at hand and various theoretical orientations that explain behavior. From these flow treatment interventions. For this case, we suggest several interventions that might be implemented. We do so from a deliberate eclectic stance. Readers need to assess their own theoretical knowledge and practical expertise and to utilize what seems most beneficial.

Adolescent depression is a complex phenomenon. It is supported by a complex interaction of thoughts, feelings, and behaviors within the adolescent and a complex tapestry of environmental factors. In Stacy's case, an effective treatment intervention should include a behavioral component with both social skills development and activity level increase; a cognitive component designed to identify, test, and modify dysfunctional beliefs related to herself, her family, and her environment as well as to monitor self-control; family interventions, designed to modify the communication and affective expression within the family and to improve the parents' consistency and effectiveness in being parents to Stacy; and school interventions designed to attend to Stacy's poor performance and moderate reading disability. Even prior to the current events in this case, attention should have been provided for early school intervention. Finally, some understanding of biological and pharmacological interventions is necessary. We begin our discussion of Stacy's case with this last issue.

Biological models of depression. Biological models of depression can be divided into two main categories, those that focus on the role of genetic factors and those that emphasize biochemical aspects of depression. Genetic factors of depression have been examined through twin/adoption studies among adults. Research has provided some interesting evidence (Kasham, Husam, Shekim, Hodges, Cytryn, & McKnew, 1981). For example, there is an average concordance rate of 76% for affective disorders in identical twins, versus 19% for nonidentical twins. Also, adoptees who experienced greater depression were more likely to have

parents who suffered from an affective disorder. Problems exist, however, in that the specific nature of genetic transmission has not been determined, nor has the role of genetic factors in the etiology of depression for adolescents been systematically researched. Nevertheless, descriptive research shows that depressed adolescents frequently have depressed parents (Schwartz & Johnson, 1985). In Stacy's case we may also be dealing with a depressed mother or father, or both.

Another biological model of depression relates to biochemical issues. Neurotransmitter actions and their interactions with antidepressant medications have been the focus of much biochemical research on depression. Whether a primary cause in depression or a secondary component, some evidence suggests that abnormalities in the metabolism of neurotransmitters are present in depressives and can be counteracted with antidepressant drugs (Kashani et al., 1981; Snyder, 1975). Although genetic or biochemical causes of depression are uncertain in Stacy's case, pharmacological interventions may, nevertheless, be needed.

Pharmacological interventions. Chemical interventions are frequently used with depressed clients. For example, since the 1960s tricyclic antidepressants have been prescribed for young patients (Hodgman, 1985). Likewise, albeit to a lesser degree, monoamine oxidase (MAO) inhibitors and lithium carbonate have also been used (Reynolds, 1985). Although frequently used in the clinical setting, the effectiveness of antidepressants has not yet been completely established through controlled research. Uncontrolled studies have reported positive results (Puig-Antich & Chambers, 1978; Robbins & Kashani, 1986). Given this uncertain and scarce evidence for the effectiveness of antidepressants, especially with adolescents, their use with this population should be carefully evaluated and monitored (Medical Economics Company, 1985). Counselors and psychologists need to have a referral network available so that this aspect of treatment is not neglected. Stacy's mood seems to have deteriorated. Consequently, referral for medical evaluation with a possibility for pharmacological intervention is an important first step in her treatment.

Intervening in the school setting. The increasing rates of depression among adolescents suggest that prevention and intervention might be effected in the school setting (Forrest, 1983). This has particular implications for the school counselor, who is in regular contact with adolescents. Assessment strategies that may be effective should consider the adolescent's cognitive and affective characteristics, environmental stressors, and current coping mechanisms (Forrest). The subsequent treatment intervention may be similar to the one we propose later for Stacy. As suggested, treatment should include a mixture of affective, cognitive, and behavioral strategies. Evidence suggests that this type of

approach has been effective in the school milieu (Coats & Reynolds, 1983).

Methods of prevention for depressive disorders are important for the practitioner, especially for the counselor in the school environment. Prevention takes two forms. Primary prevention advocates the removal of environmental or interpersonal characteristics that lead to a depressive disorder. Given the uncertain etiology of depression, this can be a difficult task (Reynolds, 1985). Nevertheless, early programs in the elementary schools that focus on affective education approaches, especially those that build self-esteem, are presumably very important. These need to be implemented. In Stacy's case, had a program been available to attend to her early school phobia and its underlying self-esteem issues, she may not have presented the later depressive crisis.

Secondary prevention, on the other hand, involves early detection and treatment of depressive disorders. Again, individuals who are most accessible to the adolescent become crucial (Robbins & Kashani, 1986). Early detection can conveniently and inexpensively be effected in the schools through group screening devices (Reynolds, 1985). If counselors and other school personnel utilize techniques of prevention within the school environment, it is highly possible that the frequency and severity of depressive disorders high-risk adolescents experience will be significantly minimized. Had such a prevention program been in place in Stacy's school, she may have been identified as being at risk earlier and appropriate interventions could have been implemented before the crisis stage.

It is reasonable to believe, and supported by the literature (Cytryn & McKnew, 1985; Petti, Bornstein, Delamater, & Conners, 1980), that a combination of pharmacological intervention along with counseling or psychotherapy might be most useful with Stacy and with most clients suffering from depression. In the case of bipolar disorders it is probably essential. The effectiveness of lithium carbonate with this type of depressive disorder has been well established. Of course, during a severe manic episode the behavior often causes problems that result in hospitalization. With adolescents, counselors and other practitioners need to be attentive to less severe mood swings or problems with a view to referral. Although the existence of a bipolar disorder does not seem probable in Stacy's situation, a medical referral for her depression remains important.

Family approaches. The above discussion of school intervention suggests an ecological perspective for the prevention or treatment of adolescent depression. An equally ecological approach is to attend to the family dynamics in Stacy's case. These dynamics are of obvious and considerable importance. Supporters of this perspective suggest that

adolescents who experience depression provide evidence that their family may be malfunctioning. A maladaptive, homeostatic family system may be maintained when the adolescent performs the role of the "sick" family member. Not surprisingly, other family members may resist any positive change in the adolescent that may risk the homeostasis of family interaction. This reality necessitates the involvement of the entire family in treatment intervention (Gattman, 1983). This might be a factor in Stacy's family. A counselor using only an individually based intervention strategy may be doomed to failure. If the family system is not engaged, it may sabotage treatment and the ultimate success of ameliorating Stacy's depression. The role of the family in the successful treatment of the depressed adolescent is crucial.

The depressed adolescent affects and at the same time is affected by other family members. Even in psychologically healthy families, dealing with a depressed member can cause great stress for the family as a whole. Mental health workers must be aware of this interaction and of the fact that normal nurturance and family care may not be effective in dealing with the depressed adolescent (Robbins & Kashani, 1986). Similarly, clinicians must be prepared to work with all family members, especially parents who may also suffer from an affective disorder and compound the problems of the depressed adolescent. If the latter case is relevant, interventions must include appropriate treatment of the parent as well as the adolescent.

Having discussed the above issues of pharmacological considerations, referral responsibilities, school interventions, and family systems concerns, the mental health worker is still confronted with a very depressed 15-year-old girl who needs individual attention and support. The deliberate eclectic, multidimensional model we are proposing is built on the foundation of a solid interpersonal relationship between the helper and the client. This relationship incorporates the basic core conditions of empathy, warmth, and genuineness that are articulated by the Rogerian school. Although this approach forms the foundation and is, thus, a "necessary" condition, it may not be "sufficient" for many depressed adolescents. Hence, we suggest the specific strategies to be discussed. In this regard the psychoanalytic model may help in understanding some of Stacy's underlying dynamics.

Psychoanalytic models of depression. Because there are various predominant psychoanalytic models, our brief discussion will focus on the classical analytic position. According to this model, a distinction is made between grief, a normal response to loss of a love object, and melancholia, an intensely ambivalent love-hate relationship with the real or imagined loss of a love object. Individuals predisposed toward melancholia are highly dependent. This dependency creates hostility toward

the focus of the dependency, but these negative feelings of anger are repressed and ultimately converted into self-hostility. Depression results from the negative impact of this "anger turned inward" on the self-esteem. In Stacy's case, her depression may be a result of feelings of hostility and anger toward her mother, father or both, which she has misdirected toward herself. Although this model has provided a stimulus from which other theories have developed, it does not provide validating empirical evidence or comprehensive strategies for the treatment of depression. Nevertheless, the psychoanalytic perspective provides an important conceptualization of the depression phenomenon. Let us turn now to two current approaches.

Current Approaches

The most influential approaches to depression are those that have demonstrated treatment success. These approaches fall into two categories: behavioral models and cognitive models (Lewinsohn & Hoberman, 1985).

Behavioral models of depression. Similarly to the proponents of the psychoanalytic model, behaviorists view depression as a result of significant loss (Kovacs & Beck, 1977; Schwartz & Johnson, 1985). Whether this be through changes in the environment, the loss of an interpersonal and reinforcing relationship, or one's failure to encourage and arrange for positive reinforcement, depression is seen as the consequential effect of inadequate or insufficient reinforcement (Ferster, 1973; 1974).

Lewinsohn's social learning theory provides a concise behavioral model of depression. This theory suggests that depressive behaviors are determined by the presence or absence of reinforcers and maintained through the reduction of response-contingent reinforcing events (Lewinsohn & Hoberman, 1985). Depression may be the result of limited positive reinforcement for the individual, which is determined by: (1) the number of potentially reinforcing events; (2) the number of these events available in the environment; and (3) the individual's social skills to elicit the accessible reinforcers (Levitt et al., 1983). Depression may also result from an excess of punishment, especially: (1) when it occurs at high rates; (2) when the individual is highly sensitive to punishment; and (3) when necessary coping skills to terminate punishment are limited (Lewinsohn & Hoberman). Unfortunately, the depressive behaviors stimulated by inadequate reinforcement are further reinforced by the concern or sympathy expressed by significant others. Eventually though, others avoid the depressed person because of the nature of his or her depressive behaviors, which minimizes positive reinforcement and further accentuates the depression (Lewinsohn & Hoberman).

Behavioral approaches. Two major behavioral strategies for treating depression are social skills training and programs to increase activity levels.

The primary goal of social skills training is to improve and increase the social skills necessary to receive positive feedback and reinforcement from others (Lewinsohn, Biglan, & Zeiss, 1976). Treatment focuses on the improvement of interpersonal style and on the development of skills, such as improved eye contact (Kaslow & Rehm, 1983). Modeling, feedback, role playing, instruction, situation logs, and homework practice are all utilized to help augment social skills and minimize the depression caused by an inability to elicit positive consequences. The prevalence of social skills deficits and the results of social skills training among adolescents have received limited attention. Nevertheless, such an approach seems especially appropriate for Stacy. Given the fact that she has had relatively little peer group interaction, "preferring the safety of her family," one might assume she has not developed effective social skills with her peer group. Indeed, she seems unable to cope with her classmates' "cruel comments." Thus, social skills training would seem to be a useful strategy to help lift her depression.

It is postulated that depression not only results from the limited reinforcement of poor social skills, but also from the lack of reinforcement that occurs when sufficiently learned and appropriate social skills are not utilized (Kaslow & Rehm, 1983). Increasing an individual's activity level, and therefore the frequency of potentially rewarding activities, may also increase the level of response-contingent reinforcement. This process will, in turn, reduce the behavioral symptoms associated with depression (Kaslow & Rehm). Here, again, a behavioral intervention seems to be an important consideration for Stacy. Unless she becomes more involved in more positive peer interactions and in positive and pleasant activities, she may have great difficulty in improving her depressed mood.

Programs designed to increase activity levels include establishing a mood/activity baseline, identifying current positive activities, increasing activities that are potentially reinforcing, decreasing activities associated with negative mood, and establishing environmental contingencies to reinforce both increased positive and decreased negative activities (Kaslow & Rehm, 1983). Scheduling more activity and using either self-managed or externally controlled reinforcement programs will also help to increase positive activities. This approach has had some results with adults (Kaslow & Rehm) and may prove useful with adolescents.

Cognitive models of depression. Research has supported the role of cognition in depression (Beck, 1967; Seligman, 1974, 1975; Rehm,

1977). The following cognitive models of depression are helpful in understanding this perspective.

The first model, proposed by Beck (1967), suggests that cognition and affects are interactive, and that the prior occurrence of cognition will determine a person's affective response to an event. If cognitions are distorted or inaccurate, the individual's emotional response will be inappropriate. Dysphoria may be the affective response of one's tendency to interpret experiences and events as negative or self-devaluative, indicating a cognitive role in the experience of depression.

Beck, Rush, Shaw, and Emery (1979) pointed to three cognitive components central to depression: the cognitive triad, schemas, and cognitive errors. The cognitive triad is composed of three negative thought patterns: a negative view of self; of the world; and of the future. Schemas, like personality traits, represent a stable cognitive pattern that individuals create in order to organize and evaluate information and events. People who experience depression develop schemas that distort environmental stimuli to coincide with a derogatory self-image. These dysfunctional or negative schemas are often created and exacerbated by faulty information processing, or consistent errors in logic, called "cognitive errors." The person suffering from depression uses these automatic cognitive errors to evaluate events, often leading to negativistic, categorical, absolute, and judgmental thinking (Levitt et al., 1983; Lewinsohn & Hoberman, 1985).

The second model of depression, Seligman's (1974, 1975) "learned helplessness" model, contends that depression exists in people who perceive that they have no control over their environment. They develop self-defeating attributions. They make internal (feeling responsible for an event), stable (the causes of an event will remain constant), and global (event outcomes will affect all areas of life) attributions for failure. In contrast, they attribute successful outcomes to external (caused by others), unstable (causes of events are transitory), and specific (situation-specific) causes (Kaslow & Rehm, 1983). This self-defeating attributional style results in the lowered motivation and reduced self-esteem common in depressed clients (Kaslow & Rehm). Although studies with adolescent populations are limited, self-defeating attributional style has been correlated with depression (Lewinsohn & Hoberman, 1985).

Rehm's (1977) self-control theory represents the third cognitive model of depression. Problems of self-control are manifested through deficits in three cognitive processes: self-monitoring, self-reinforcement, and self-evaluation. Depressed clients fail to view situations with an orientation to the future and tend to concentrate on immediate consequences of events (Gilbert, 1984). They selectively attend to negative

outcomes and focus on immediate reinforcements. A negative view of the self, the environment, and the future results.

Similarly, depressed individuals tend to attribute negative events to either external causes beyond their control or to internal, unchangeable deficits in the skills necessary to create change. They tend to set high standards for positive self-evaluation, while at the same time exhibiting low standards for negative self-evaluation. Reduced self-esteem and an increased feeling of helplessness result from these maladaptive structures of self-evaluation (Lewinsohn & Hoberman, 1985).

Cognitive approaches. Depression treatment strategies flow directly from these three cognitive models. For example, Beck et al. (1979) developed a cognitive therapy with both behavioral and cognitive components designed to reduce automatic negative cognition with the goal of challenging the assumptions that maintain these faulty cognitions. Because clients often have difficulty utilizing cognitive tasks, behavioral strategies should be used first in the therapeutic process. Similarly, positive activities should be established and augmented through strategies such as role playing, graduated task assignments, assertiveness training, activity schedules, and behavioral rehearsal before cognitive interventions are employed (Lewinsohn & Hoberman, 1985). Thus, the earlier suggestions to involve Stacy in social skills training and to help her increase pleasant activities become even more important.

After these strategies are successfully utilized, emphasis is moved to cognitive interventions that emphasize identifying, testing, and modifying cognitive distortions. Strategies that have been successfully used (Kolko, 1987) include: (1) recognizing the connection between cognition, affect, and behavior; (2) monitoring negative automatic thoughts; (3) examining evidence related to distorted automatic cognition; (4) substituting a more realistic interpretation for distorted cognition; and (5) learning to identify and modify dysfunctional beliefs (Kaslow & Rehm, 1983). Such a strategy could be utilized with Stacy.

Seligman's (1981) treatment approach is an outgrowth of his learned helplessness model of depression. It challenges the faulty attributions of control and efficacy that depressed individuals often make (Kolko, 1987). Focus is placed on: (1) enriching the environment to assist in effecting more desired outcomes while decreasing unwanted ones; (2) developing expectations of control through control training; (3) reducing preference for unobtainable outcomes through resignation training; and (4) changing attributions to replace unrealistic expectations. Similar to other approaches, this model has had no reported applications with adolescent populations.

The final cognitive approach for depression is based on Rehm's self-control model. This intervention has been described as a primary

prevention method, useful in teaching the skills necessary to avoid depression (Kaslow & Rehm, 1983). Kolko (1987) recommended that treatment in self-control involve specific training to, for example, monitor positive events and self-statements, engage in positive effect behaviors and cognitions, emphasize long-term positive consequences and develop more realistic and achievable goals, make more legitimate attributions, and create more frequent self-reinforcement. In Stacy's case, the depression is current. Devising ways to help her increase her positive and decrease her negative self-talk is very important.

There are two cognitive techniques that the authors have found to be particularly helpful. First, ask the client to repeat a standard, positive phrase, such as "I am a good and worthwhile person" *every* time the client pushes in a car brake while driving. Second, ask the client to write down on three-by-five cards a positive, affirming self-statement (e.g., "I am an honest and trustworthy person." "I am attractive and caring.") When three or four cards are completed, add one blank card and place them inside the client's cigarette pack. Each time a cigarette is taken, the client silently reads one of the cards. When the blank card turns up, the client must spontaneously make up a new, positive sentence.

Of course, if Stacy doesn't drive or smoke, these techniques need to be modified to fit her situation. Several principles are important. Negative thoughts cannot coexist with positive ones; positive thoughts need to be tied to new cues; and, positive thoughts need to occur with frequency.

Conclusions and Implications

The approaches mentioned above may be useful for the case study presented. Because we suggest a comprehensive and multidimensional approach to treating Stacy, the cognitive, behavioral, and family interventions described above might all be employed to attend to the multicomponent nature of her depression. Dealing with the family's limited support of Stacy; developing Stacy's social skills, level of activity, and interaction with her peers; and helping Stacy manage her cognition about herself, her environment, and her future are all plausible, and potentially necessary focuses of treatment.

Depression is an emerging, significant, and complicated mental health problem among adolescent populations. Its manifestation in adolescence is similar to that found in adulthood. It has been linked to other at-risk factors among adolescents such as suicide, school attrition, behavior problems, and substance abuse (frequently used as self-med-

tication for depression)—further augmenting the difficulty in making appropriate diagnosis and establishing effective treatment interventions. Because research with normative populations is limited, further research is needed to gain a better understanding of the frequency and severity of this disorder and of the effectiveness of depression treatment models among adolescents. This is especially important given the relative lack of attention and recognition of this disorder among adolescent populations (Friedman, Clarkin, Corn, Aronoff, Hurt, & Murphy, 1982; Husain & Vandiver, 1984).

Depression can have a catastrophic effect on adolescents and on those around them. The prevention of depression and the provision of early treatment in the presence of this disorder are essential. Because parents, school counselors, and other school personnel play primary roles in the lives of adolescents, they must be especially aware of and responsive to the symptoms, causes, and related problems of depression. Identification, awareness, and quick response by parents and mental health professionals may be of paramount importance in avoiding the severe and devastating effects of depression on the adolescent.

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Chapter 7

THE SOCIETY WE LIVE IN: STRESS AND COPING

Art Terry and Sylvia Milliken

Case Study

This chapter begins with a case study of an at-risk youth. The authors invite the readers to think about some interventions they would use with him as they read this chapter. Some recommendations for areas of exploration will be presented after the applications and interventions section of this chapter.

Robert is a Black, 16-year-old who has lived in foster care homes for over 3 years. His parents don't have either the means or interest to care for him. He occasionally sees his father, but the father is not a significant influence in his life. He sees his mother even less frequently—the last time he saw her was over a year ago. She reportedly is a prostitute.

Robert has difficulties in his foster care home because he feels he is treated unequally and unfairly compared to the other youngsters living there (two biological children and 2 other foster children).

Robert does poorly in school. Although he seems to be of average intelligence, his GPA is only 1.2. Although his attendance in school is fair, he views school as difficult and irrelevant. He is very social and his charming personality is his greatest asset.

Robert has the usual teen stressors of low self-esteem, poor self-identity, and a negative body image. He is good looking, but thinks he is a little short. Some additional stressors are: lack of spending money; difficulties at home; lack of positive role models (especially from the Black community); difficulty with the discipline required for holding down a job; and poor coping skills.

Robert is flirting with gang membership and is becoming increasingly involved in their activities. He wears the gang "color" and hangs out with other gang members. He finds the violence exciting and fascinating. He is like a tourist voyeur on the gang vista. Although he is ostensibly aware of the downside of gangs, that aspect seems distant and unreal. He sees gang members as having the most money, power, and success when compared to other Blacks.

Introduction and Problem Statement

The Problem

Due to the rapid changes and incredible growth of knowledge, technology, and competition in our society, stress has become a major problem—particularly for children (Youngs, 1985). Youth experience stress, and their anxieties are just as stress-producing as those of adults (Henry, 1980). However, youth may not understand when they are reacting to stress and therefore may not know methods for dealing with stress. The challenge for concerned counselors, teachers, and other helping professionals who work with youth is to help young people and themselves learn to balance the stress in their life to ensure maximum physical, psychological, and social well-being. The purpose of this chapter is to present a holistic approach to stress management and coping skills for at-risk youth.

The objectives of this chapter are: (1) to present a case study for exploration in terms of effective stress coping skills; (2) to describe the stress response mechanisms and the effects of stress; (3) to review the literature by exploring the stressors in the daily life of youth in three areas—relationships, biological/developmental, and individual; (4) to examine applications and interventions—such as support systems and healthy coping mechanisms and interventions; (5) to further explore the case study; and (6) to make some general recommendations and suggestions for implementing the coping skills explored in this chapter.

The Stress Response Mechanism

The early work on stress was done by the 19th-century French physiologist Claude Bernard, and later continued by Harvard physiologist Walter B. Cannon. *Stress*, as a medical term, was coined by Austrian-born Hans Selye, an endrocrinologist at the University of Montreal. He provided the first significant breakthrough in stress research and is

commonly referred to as the "father of stress" (Abel, 1974; Ivancevich & Matteson, 1980; Selye, 1956, 1975).

There are many definitions of stress. For the context of this chapter: "Stress is the perception of threat or expectation of future discomfort that arouses, alerts, or otherwise activates the organism" (Woolfolk & Richardson, 1978, p. 8). If prolonged, stress can fatigue or damage the body to the point of malfunction and disease. The agents or stimulus conditions are called the "stressors" (Abel, 1974; Girdano & Everly, 1979; Ivancevich & Matteson, 1980).

Alarm. Selye labeled three distinct phases of the defense reaction: alarm, resistance, and exhaustion. Alarm is usually considered the most important phase. It involves a series of complex biochemical alterations. These cause the body's system to be speeded up, release energy-rich sugar to the blood, accelerate the blood clotting mechanism, and strengthen muscle functioning. In addition, breathing is speeded up, blood cells are released from storage into the circulation, the senses become keener, and the digestive system becomes temporarily inactive. The stress response causes the body to be geared up for "fight or flight" (Abel, 1974; Girdano & Everly 1979; Ivancevich & Matteson, 1980).

Resistance. During the second phase the body increases its resistance against the stressors. Unfortunately while resistance to a particular stressor is unusually high during the resistance phase, it is often unusually low to other stressors, leaving the individual more prone to illness (Ivancevich & Matteson, 1980).

Exhaustion. The third and final phase is called the exhaustion stage. Selye emphasized that each individual has a limited amount of "adaptation energy" to withstand stress. Once this has been expended, there is no known way to replenish it (Ivancevich & Matteson, 1980; McQuade & Aikman, 1974). Sometimes this stage is known as "burnout" because the body has used up its supply of life energy. Because of the incredible energy youngsters expend, they are particularly vulnerable to burnout (Youngs, 1985).

The Effects of Stress

In the book *Stress* by T. Cox (cited in Ivancevich & Matteson, 1980), the following classification of the consequences of stress are listed:

1. *Subjective effects:* Anxiety, aggression, apathy, boredom, depression, fatigue, frustration, guilt and shame, irritability and bad temper, moodiness, low self-esteem, threat and tension, nervousness, and loneliness.

2. *Behavioral effects:* Accident proneness, drug use, emotional outbursts, excessive eating or loss of appetite, excessive drinking and smoking, excitability, impulsive behavior, impaired speech, nervous laughter, restlessness, and trembling.
3. *Cognitive effects:* Inability to make decisions and concentrate, frequent forgetfulness, hypersensitivity to criticism, and mental blocks. (pp. 13–14)

In addition, the biological effects of stress are many and varied. Some are direct, whereas others—perhaps most—are indirect or have secondary results. Stress can be positive when it results in increased drive and self-motivation. However, most of the effects of stress are disruptive and potentially dangerous. Stress is strongly associated with many illnesses including ulcers, high blood pressure, heart disease allergies, and headaches. Prolonged stress can also impair an individual's immune responses, decreasing the body's ability to fight invading bacteria and viruses. It is estimated that more than 50% of all medical problems are stress-related (Abel, 1974; Girdano & Everly, 1979; Ivancevich & Matteson, 1980).

Review of the Literature

This section addresses causes of stress in the daily life of youth. It will be divided into three areas. The first area, relationship stressors, deals with factors or pressures that are exerted on the at-risk youth by others with whom he or she has a relationship. The second area describes the impact of biological and developmental stressors for developing youngsters as they strive toward autonomy. The third area covers the individual-level stressors that affect and characterize the youth as an individual.

Relationship Stressors

Peer pressure. High on the chart of relationship stressors for youth is the effect of peer pressure. There is sufficient evidence in the literature to show that as the youth becomes an adolescent, he or she uses social comparison in evaluating performance. Eleanor MacCoby notes that young people become increasingly aware of and sensitive to the reactions of others to self (Henry, 1980). The adolescent peer plays an important feedback role for the receiving adolescent. Adolescents become vulnerable to humiliation by their own behavior if it contradicts their desired image and if it differs from their peer group.

Sexuality. Issues around sexuality are very stressful for teens. Research indicates that the teen years are an age of uncertainty about sexuality—there is a desire to experiment, or to prove oneself in the sexual arena (Dean, 1972). For teens, there is often a constant questioning of adequacy and normalcy in regard to sexuality. In the senior high school age group, the Life Events List has been used to identify stressors. Three of the top five life change events causing stress have to do with sex and sexuality: getting married, unwed teenage pregnancy, and becoming a teenage father (Dean).

Sex has become an issue for more young people at an earlier age than in previous generations (Youngs, 1985; 1986). On the one hand, parents tell their children not to have sex until they are married, and on the other hand, the media (and often the parents' own actions) give a contradictory message of promiscuity and experimentation. Research indicates that nearly a quarter of the girls between the ages of 15 and 19 have had sexual intercourse before the age of 16 (Youngs, 1986). Indeed, in 1984, the rate of illegitimate births among teenage girls was almost double that of 1970 (Youngs, 1986).

Performance expectations of significant others. Today's youth are increasingly pushed into independence and self-reliance before they have the skills and abilities with which to cope (Youngs, 1985). One frequent stressor is that often each family member may be going in a different direction, resulting in families spending little time together. In addition, parents today are having fewer children, which can have the effect of increasing the pressure on each individual child.

Third, young people may be constantly pushed to compete with others and be the "winner" at everything they do. Even play, which used to be for fun and socialization, is often organized and structured for children by adults.

Most of the 60 million Americans under 18 aren't candidates for therapy, but mental health professionals and child experts are alarmed by the rising proportion of troubled youth (Whitman, 1986; Youngs, 1986). In fact, psychologist Nicholas Zill pointed out that "up to 35 percent of American kids suffer stress-related health problems at some point" (Whitman, 1986, p. 58).

Cultural considerations. In addition to the relationship stressors listed earlier, some cultural considerations need to be included. Edward L. Thomas (1965) is a medical physiologist who has studied the reactions to stress from a cultural perspective. He pointed out the drastic stresses of non-Western groups who are undergoing rapid, extensive acculturation.

> The whole pattern of life undergoes changes—diet, work, sleep, clothes, shelter, muscular habits, physiological rhythms,

> as well as family relationships, religion, ideas, and aspirations. All of these forces may generate physiological changes. (p. 166)

These individuals are subjected to adjusting to wholesale changes in life-style that can bring about "culture shock" and result in changes in appetite, hostility, anxiety, frustration, depression, and suspicion (Pedersen 1979; Thomas, 1965).

Biological/Developmental Stressors

The second type of stressors are the biological and developmental stressors that are connected with the process of individuation and separation. These include three areas: biological/developmental maturation; separation and individuation; and the psychological aspects that affect the youth during latency and adolescence.

Biological/developmental maturation. The first area of biological/developmental stressors has to do with the enormous biological and developmental changes that take place as a child moves through latency (age 6 to 11) and adolescence (age 12 to 16) and young adulthood (age 17 to 21). These changes cause stress for youngsters and all those in their environment. Physical maturation is escalated during adolescence, bringing about rapid physical growth and major hormonal shifts as the youth makes the uncomfortable transition into sexual maturation and adulthood. All this rapid change in the body can be both exciting and frightening for the youth and the family. "As a result of sexual maturation, new social expectations about sexual roles and norms of behavior are imposed by the family, school, peers, and the media . . . " (Preto & Travis, 1985, p. 26). Family support is critical to help the adolescent deal with these rapid changes. Unfortunately, at-risk youth often have little, if any, family support or stability.

Separation and individuation. "Although the process of identity formation and separation are really lifelong, puberty is a time of their acceleration" (Preto & Travis, 1985, p. 25). As the central nervous system matures, there is a shift from concrete to abstract thinking, and the youth begins to become an individual. Kaplan (1987) considered this to be a pivotal shift: " . . . this developmental advance in thinking between twelve and sixteen is from the more concrete, present-oriented, simplistic, right/good versus wrong/bad to the general, formal, logical, and abstract" (p. 151).

Separation involves the process of the child becoming separate from the mother, and individuation results from those achievements that establish the child as an individual. Kaplan (1987) clearly stated the distinction between separation and individuation:

> The separation process includes boundary formation, distancing, and disengagement from the mother culminating in the realization that mother and others are outside the boundaries of self. Individuation comprises the organization and control of perception, memory, cognition, and reality testing. (p. 139)

The role of the family plays in the adolescent's task of becoming a separate and autonomous individual cannot be downplayed. When the family is stable and supportive, it allows the youth to experiment and yet be protected so that individuation can take place. The parents need to be consistent with limitations, expectations, and consequences of behavior. They also need to show consideration for the adolescent's transition into adulthood and independence.

Parents can respond to the adolescent's dependency needs by setting clear limits and expectations, and, at the same time, respect the adolescent's struggle for independence by being flexible and willing to change rules in the family (Preto & Travis, 1985).

Psychological. With the advent of latency and the forming of the superego, one normally sees a shift from extreme dependence on the approval of parents to increasing self-control and self-awareness (Kaplan, 1987). Kaplan cited Laufer, who emphasized that in addition to separation from parents, the adolescent has the additional tasks of "mastering aggression, achieving heterosexual love relationships, and planning and commitment to future goals" (p. 152).

Kaplan (1987) divided the focus of typical adolescence into three phases: "first, the body and parents; second, sexual identity and the relationship to the other sex; third, goals, standards, and the relationship to society" (p. 153). This reorganization and redefining of self can bring about tremendous stress for the youth, and result in emotional and behavioral disturbances that can be lessened if the youth has a supportive, empathetic family.

Individual Level Stressors

The third category of stressors are individual-level stressors. This section includes a review of personality types, stability of the family, negative impact of a poor diet, and career/vocational stressors.

Personality types. Research has established that certain personality types are more prone to stress and illness than others. They have been classified as Type A Personalities. Type A personalities tend to be always in a hurry, take on too many tasks, find it difficult to relax, and tend to be demanding and critical, especially of themselves, and become defensive when criticized by others. They become impatient when con-

fronted with delays, or with people they view as incompetent; they measure their success in terms of numbers (numbers of reports written, patients seen, etc.); they often try to perform many tasks at the same time; and they usually feel they have to do everything themselves rather than delegating. The are commonly referred to as "overachievers" (Girdano & Everly, 1979; Ivancevich & Matteson, 1980).

Individuals who do not exhibit Type A characteristics are known as Type B Personalities. They are able to: relax without feeling guilty; work without becoming agitated; be free from that sense of time-urgency of the Type A person; keep from getting angry easily; and be free from the need to display or discuss achievements (Girdano & Everly, 1979; Ivancevich & Matteson, 1980).

Many studies have shown the negative effects of Type A behavior on the heart. One well-known study is that of Friedman and Rosenman (1974). It showed a strong link between Type A behavior and heart disease (Girdano & Everly, 1979; Ivancevich & Matteson, 1980). "Changing Type A behavior generally consists of reestablishing priorities, allowing more time for each activity, and diminishing the total number of activities" (Ivancevich & Matteson, p. 184). Clearly, reducing pressure on youngsters to achieve, allowing them to mature at their own pace, and helping the Type A's to become Type B's would be recommended.

Stability of the family. Magid and McKelvey (1987) gave a chilling and shocking account of how society is creating more and more people who are without a conscience. They claimed that the lack of early bonding of the infant with a primary caregiver results in a lack of attachment and the development of an Antisocial Personality Disorder (APD).

> Factors responsible include: the increasing numbers of mothers working outside the home, the child-care crisis, the teen-pregnancy epidemic, a high divorce rate, increasing child abuse and neglect, the shambles of the foster-care system, and too-late adoptions. (pp. viii)

Without the early and continued support of the family, children are unable to form an affectional bond that allows them to establish and maintain healthy relationships. The consequence of this failure to bond is that youngsters are put at risk of becoming individuals with APD. They are "psychopaths, [who] express no remorse if caught in wrongdoings. They are aggressive, reckless and cruel to others" (p. 4).

Adolescents who run away from, or are put out of the home by their parents, are at high risk of experiencing violence and drug abuse. Also, without the stability of a supportive family, they are vulnerable to a life-

style that includes "unemployment, underemployment, prostitution, and involvement with an abusive partner" (Preto & Travis, 1985, p. 30).

Negative effects of a poor diet. In the 1940s, Dr. Tintera found a connection between hypoglycemia (low blood sugar) and children with behavior or learning problems (Dufty, 1975). Hypoglycemia is often caused or aggravated by eating sugar. Cheraskin, Ringsdorf, and Brecher (1974) reported a study conducted by Rojas and Sanchi in 1941 about 129 juvenile delinquents who had been involved in crimes against persons. They found that 116 were hypoglycemic. Specialists have been successfully treating patients with behavioral problems by eliminating offending foods (Youngs, 1985). Youngs goes on to say:

> Studies since then have suggested that adverse reactions to foods can be one of the causes of hyperactivity, nervousness, stealing, learning problems, minimal brain dysfunction, depression, hostility, aggression, irritability, stress, and periods of confusion.
>
> Many foods have been found to be major causes of children's stress-related behavior problems. The primary offenders are soft drinks, cake, cookies, candy, ice cream, and sugared cereals. When these are removed from a youngster's diet, their behavior improves significantly. (p. 70)

Numerous other studies show similar findings of the detrimental effects of sugar on behavior (Bland, 1985; Davis, 1970; Smith, 1985). Youngs (1985) indicated that many experts in nutrition make the following recommendations for youngsters who are under stress:

- Eat at least three, evenly spaced, well-balanced meals each day.
- Consume adequate protein daily, whether animal or vegetable.
- Consume fresh fruits and vegetables daily.
- Use only whole grains.
- Include legumes and nuts in the diet.
- Use sparingly salt, dried fruits, coffee, tea, or tobacco.
- Allow a fruit, vegetable, or protein snack between meals or before your child's bedtime. (pp. 75–76)

It is also recommended that youth include supplements, such as calcium, Vitamins C, E, and B complex. These can actually strengthen the body's ability to handle stress (Bland, 1985; Davis, 1970; Youngs, 1985).

Career/vocational stressors. Another stressor for youth is the pressure caused by the overwhelming options and choices they are confronted with in terms of ideologies, careers, and life-styles from which to con-

struct their future. The abundance of choices causes stress because it contributes to ambiguity (Youngs, 1985).

In addition to the difficulty of career choice and employment options, a young person faces an uncertain future that is further beclouded by possible annihilation through overpopulation, pollution, or nuclear warfare. There is often a sense of hopelessness in making decisions premised on a future that may not be. Adults often look at young people and assume that they should be grateful that they have their whole life ahead of them. What they forget is that from the adolescent perspective, if they are hurting now, they tend to think that the future will also be filled with pain (Youngs, 1986).

At-risk youth need guidance in many areas in order to destroy career and vocational myths concerning employability. They are entitled to the best occupational information available. They are entitled to know their skills, aptitudes, interests, and competencies in order to make wise choices. At-risk youth can be better prepared for the world of work as a result of the many training programs available. A few of these would include: internships; skills training through Private Industry Councils; cooperative programs that match employers and youth; Experience Based Career Education (EBCE) that enables youth to learn in one or more work sites under the supervisor of a team; and finally work experience programs supported by their high school.

Applications and Interventions

Support Systems

Helping youth, particularly at-risk youth, develop a support system of peers and adults is crucial. A good support program should include teaching youth to: understand the value of a support system; identify their support system; strengthen or add to that support system if needed; identify how their supporters "support them"; turn to others during times of stress; become aware of others' stress and how to be supportive to them (Youngs, 1985).

Peer support. This section includes two types of peer support—The Natural Helper Program (one-on-one support) and peer support groups.

In a recent videotape shown on television entitled *It Shouldn't Hurt to Be a Kid: The Natural Helpers Story*, the benefits of a peer support program for high school students was illustrated (Hirsh, 1988). The Natural Helper Program will be highlighted here because it is such an excellent example of positive peer support. At the time of airing more

than 15,000 young people had been trained in the state of Washington. The program was started in 1979 at Mercer Island High School, located near Seattle. Young people are selected by their peers through a survey asking them to identify who they trust and what issues are important to them. The real strength of the Natural Helper Program lies in the fact that peers are so important to teens. When teens are in trouble, they tend to go to peers, and this program teaches those peers to be more effective helpers. The youth selected is called "A Natural Helper" because he or she is someone who already listens to, and is trusted by, other young people.

Teens are beset with problems from many areas such as drugs, sex, depression, suicide, and family disintegration. This program takes students who are already good listeners and teaches them to go beyond listening—to do something about the pain their peers might be experiencing. The program emphasizes that the young people selected are "helpers" and not "counselors." To become a counselor requires more skill and training than a 3-day retreat can provide.

Claire Roberts, one of the co-founders of the program, delineates some of its strengths: (1) Young people are selected by their peers as someone they trust and would go to with problems; (2) Each group is represented by "Natural Helpers" (jocks, hoods, heads, honor society, etc.) so that a true cross-section of the school is provided; (3) Adult support for the Natural Helper is provided by training adults from the school in this program also. These adults can be staff members at the school who are selected by the students.

The peer support group is another tool that can serve as a constructive experience for youngsters, particularly those who are intimidated, isolated, or fear rejection. Peer groups can help shape the experiences of the adolescent culture by determining the framework in which the adolescent gains appropriate, supportive experiences. Youngs (1986) listed some of ways a peer support group might be of benefit to youth:

- Developing a positive self-image;
- Adjusting to new situations and roles;
- Developing emotional balance;
- Reducing isolation by sharing experiences;
- Being exposed to positive role models; and
- Getting reliable feedback about behaviors and goals.

Crisis management options. In the areas of crisis, women tend to help each other more than men (Witkin-Lanoil, 1986). However, both men and women would benefit from learning techniques that teach them how to help themselves and others.

As indicated earlier, peers can be supportive to each other. However, when stress is at a crisis level, professional intervention by individuals who are specifically trained to deal with crisis situations is essential. A 24-hour crisis phone line should be available as well as a drop-in center where teens can freely and openly discuss their problems. Professional help is required if any of the following are reported: feeling overwhelmed, having suicidal impulses, having homicidal fantasies or impulses, or becoming increasingly dependent on drugs or alcohol to ease the pain.

Providing information. Making available information that is of key concern to youth, parents, teachers, counselors, and the community through various media and in various forms is another form of positive support. We suggest that written material addressing key issues in the form of books, pamphlets, and brochures be made available at drop-in centers, counseling offices, and throughout various locations so that youngsters and other interested persons might have easy access to them.

The media can help through presenting both local and national television programs and movies about some of the crucial issues presented in this book. Television can also help by having meetings on local talk shows or programs where youngsters are encouraged to talk openly about their concerns. Newspapers, libraries, schools, and community centers can also make a contribution by informing the public about some of these issues and having interesting films and speakers.

Healthy Coping Mechanisms and Interventions

Although it is beyond the scope of this chapter to provide a detailed description of all the approaches available to developing effective coping skills for stress management, we have listed nine interventions that we think are particularly effective. They are: Rational Emotive Therapy (RET), Self-Instruction Therapy (SIT), Stress Inoculation Training, Multimodal Behavior Therapy, Overcoming Test Anxiety, Time Management, Problem Solving/Decision-Making, Relaxation Techniques, and Physical Activity.

Rational Emotive Therapy (RET). Adolescents think that parents and the events in their lives cause them to feel the way they do. Thus, they often blame someone else for their feelings of stress and emotional upset. In doing this, however, they often neglect an important factor, the fact that the way they think determines their behavior, and thus their responses to stressful situations. Sometimes, even when they are aware that thoughts somehow lead to feelings, they might fail to realize that they actually have the ability to change unwanted or irrational thoughts voluntarily so that different emotional feelings will result. When teen-

agers practice cognitive restructuring, positive outcomes generally result. There is usually an increase in positive thinking, greater ability to cope with stressors, and a reduction of tension between the teen and significant others.

Albert Ellis, developer of Rational Emotive Therapy (RET), is perhaps the best known therapist for teaching people how to deal with irrational thoughts. Ellis reminds us that from time to time, most people engage in faulty or irrational thinking (Ellis, 1985; Kranzler, 1974). What people think or say to themselves before, during, or after an incident greatly influences their feelings and behaviors.

Practitioners of RET use a variety of cognitive, affective, and behavioral techniques. RET teaches clients to: challenge their own irrational beliefs; avoid the use of catastrophizing phrases such as "It's awful," "It's terrible," and "I can't stand it"; dispute overgeneralizations and global thinking such as "all," "never," "should," and "shouldn't"; separate their self-worth from their performance; use cognitive homework; learn to change their language; use rational-emotive imagery; and use role playing. RET ideas have been incorporated by many therapists and are presented in a variety of works (Corey, 1986; Ellis, 1985; Ellis & Harper, 1975; Kranzler, 1974).

Self-Instruction Therapy (SIT). SIT, developed by Donald Meichenbaum, is also effective in dealing with irrational thoughts and fears. It is a form of Cognitive Restructuring, which is a name given to techniques that deal with restructuring thoughts. Self-Instruction Therapy (SIT) also focuses on self-statements. However, this approach differs from RET in that Meichenbaum puts less emphasis on logical analysis of irrational beliefs and places more importance on teaching the child to learn to solve problems and to control his or her own behavior. Meichenbaum suggests a three-phase change process: self-observation; new internal dialogue; and learning new skills (Corey, 1986). The therapist assists the child to develop answers to four key questions: What is my problem? What is my plan? Am I using my plan? and How did I do? (Meichenbaum, 1977; Ramirez, Kratochwill, & Morris, 1987).

Stress-Inoculation Training. This is another cognitive restructuring technique developed by Meichenbaum. "[The procedures] are a psychological and behavioral analogue to immunization on a biological level" (Corey, 1986, p. 232). Clients are given opportunities to deal with relatively mild stimuli and gradually are exposed to stronger stimuli. In this manner, they build up a tolerance for stressors.

The stress-inoculation program has three phases. Phase one is the Educational Phase, which involves monitoring of self-statements and identifying their effect. Therapists are cautioned to be flexible and "respectful of the individual, cultural, and situational attributes of their

clients" (Corey, 1986, p. 232). Phase two is the Rehearsal Phase. This consists of information gathering about situations that cause clients fear, making adjustments to lessen the fear, and learning methods of relaxation. Some coping self-statements typically rehearsed in phase 2 are: What can I do to prepare for this? How can I meet this challenge? What can I do to cope so that I won't feel overwhelmed? and How can I acknowledge myself? Phase three is the Application Phase, which involves practicing increasingly challenging behavioral assignments. This final phase is where all the techniques learned in the two earlier phases are put into practice in the client's personal life (Corey, 1986; Meichenbaum, 1977).

Multimodal Behavior Therapy. One of the most thorough interventions is Multimodal Behavior Therapy, which was developed by Arnold Lazarus. This model is effective because it is holistic and therefore deals with: minimizing the frequency of stress; preparing the individual, psychologically and physiologically, to withstand excessive stress; and educating the individual about exercises and activities that dissipate the physical by-products of stress arousal (Bailey, 1977; Girdano & Everly, 1979).

This approach was chosen to be highlighted because it is an eclectic approach, and therefore is easier to adapt for usage with the widest variety of clients. It draws from a number of therapeutic styles and techniques such as anxiety management, hypnosis, meditation, modeling, positive reinforcement, positive imagery, relaxation training, and thought stopping (Corey, 1986; Lazarus, 1976, 1986; Tolman & Rose, 1985). It also addresses the importance of diet, drugs, and exercise, which are effective tools in stress reduction.

Lazarus gives the client a preliminary questionnaire, followed by a detailed life-history questionnaire to get a clear picture of the client. The counselor helps the client develop skills by providing instruction, information, and feedback to the client, and by using homework as an important part of the learning process (Corey, 1986).

According to Lazarus, human beings are complex and therefore require multifaceted interventions (Corey, 1986). Lazarus believes there are seven major areas of personality functioning: behavior, affect, sensations, images, cognitions, interpersonal relationships, and biological/drugs function. He uses the acronym "BASIC ID" to represent these. The "D" represents the last component, which consists of drugs, medicine, nutrition/diet, hygiene, exercise, and the person's general biological functioning (Corey, 1986; Lazarus, 1976, 1986).

Overcoming test anxiety. Test anxiety is all too common for many students. Because taking tests is a necessary requirement for passing classes and graduating, and can be a positive indicator of the student's understanding of a subject, it is beneficial to provide an intervention

that will help the student learn to break the "anxious cycle." Generally speaking, the reasons for test anxiety are three-fold: (1) poor study skills; (2) poor time management; and (3) negative self-talk.

Anxiety reactions can be a vicious cycle of obsessive thoughts. Such is the case when a student is experiencing test anxiety. The following technique combines several concepts, and it can be generalized to other areas of the youth's life such as dating, work, and improving self-esteem (Corey, 1986; Ellis & Harper, 1975; Lazarus, 1976).

A. Thought-stopping—of negative self-talk;
B. Systematic desensitization;
C. Setting realistic goals and acknowledging self; and
D. Establishing good study skills.
    1. Schedule definite study times;
    2. Study in same place if possible;
    3. Avoid distractions (T.V., radio, and people);
    4. Reward yourself when you keep the schedule; and
    5. Take smaller tests regularly and evaluate.

Time management. Alan Lakein (1973) pointed out the importance of time management in helping a person take control of his or her life. Teaching youngsters good time management will help them accomplish more effectively goals they set for themselves throughout their life. Lakein advised that "planning is bringing the future into the present so that you can do something about it now" (p. 25). Encouraging youngsters to know and respect their own personal values is crucial if they want to make effective, satisfying decisions they can live with (Gelatt, 1972; Krumboltz, 1966; Simon, Howe, & Kirschenbaum, 1972).

Some time management suggestions were given earlier in the section on overcoming test anxiety and developing effective study skills. However, for both short-term and long-term planning, it is important to make a list and set priorities based on one's own personal values. The youth determines the relative value of each item and places an "A" beside those that are of high value, a "B" beside those that are of medium value, and a "C" beside those that are of low value. Because the "A" items are of highest value, and will give the youth the highest return on investment of time, they should be attended to first. Next, the youth should work on the "B" items, and finally the "C" items. The youngsters' ABC's will probably change over time, but the process will serve them well throughout their life, both personally and professionally (Lakein, 1973).

Problem-solving and decision-making skills. Effective problem solving requires individuals to accurately and realistically look at their life and identify problems. A simple five-step process can help with this:

1. What is the problem?
2. How have I tried to solve this problem?
3. What other solutions are there?
4. Choose a plan and implement it.
5. Evaluate the results and recycle if necessary.

Youngs (1985) claimed the following benefits for children in terms of problem-solving ability:

> Children need to learn the skills of problem-solving in order to reduce stress, maintain stability, and achieve worthwhile goals. And as an adult, being an effective problem-solver will lead to success in all areas of life, both personal and professional. (p. 159)

The balance sheet model is a simple decision-making model and is useful when one has to choose between several alternatives. The youth lists the alternatives—one at a time at the top of the page on separate sheets of paper—and draws a line down the middle of the paper. On the left hand side the youth lists all the liabilities (cons) and on the right hand side lists all the benefits (pros). This works well for decisions that have a low impact or don't require a more thorough investigation.

Two other problem-solving approaches were presented earlier in this section—Self-Instruction Therapy and Stress Inoculation Training by Meichenbaum. Other problem-solving and decision-making models can be found in a variety of sources (Corey, 1986; Gelatt, 1972; Krumboltz, 1966).

Relaxation techniques. These interventions allow individuals to become better prepared, psychologically and physiologically, to withstand excessive stress. Meditation, biofeedback, relaxation training, listening to relaxing music, and doing slow stretching exercises such as yoga are all techniques designed to help the person slow down and achieve muscle and mental relaxation (Benson, 1975; Dean & Tager, 1981; LeShan, 1974).

Deep and regular breathing is generally associated with producing relaxation. In addition, by focusing on pleasant images (guided imagery) and thoughts, clients can learn to release tension. Another component of relaxation training generally includes having the client tense his or her muscles on purpose so they can begin to make the distinction between tension and relaxation.

Meditation can take many forms including prayer, focusing on slow, deep breathing, listening to slow movements of music, or using guided imagery. Or it can be a more formalized type meditation such as Transcendental Meditation (TM), developed by the Maharishi Mahesh Yogi, or the Benson technique, both of which are credited with bringing about

such positive outcomes as "reduced heart rate, lowered oxygen consumption, and decreased systolic and diastolic blood pressure" (Ivancevich & Matteson, 1980, p. 218).

Biofeedback is a relaxation technique that teaches the person to become aware of the effect of thoughts, messages, and emotions on his or her physiological state. The typical biofeedback system involves the person being hooked up to an electronic instrument that monitors and gives feedback (visually or auditorially) while he or she is learning to control various bodily functions such as blood pressure, heart rate, or body temperature. This awareness and feedback allows the person to bring about a state of deep relaxation. Biofeedback has been successfully used in many relaxation training programs (Girdano & Everly, 1979; Ivancevich & Matteson, 1980; Youngs, 1985).

Physical activity. Although relaxation techniques will help alleviate the tension at the time of stress, there needs to be some aerobic exercise to completely dissipate the by-products created when one is stressed (Abel, 1974; Bailey, 1977; Girdano & Everly, 1979).

To maintain good health, it is generally recommended that one participate in some sort of aerobic exercise for a minimum of three sessions a week for a minimum of 20 minutes each. Some studies show that one needs to exercise at least five or six times per week to improve health and increase resistance to stress. Aerobic exercise is activity that increases the heart rate and circulation. This will maximize the supply of oxygen to the tissues, help remove waste products more efficiently, and tone the muscles. It often has a beneficial side effect by the releasing of endorphins, the body's natural opiates. The release of endorphins will cause a feeling of well-being and it is often what runners refer to as a "natural high" (Abel, 1974; Bailey, 1977; Girdano & Everly, 1979; Ivancevich & Matteson, 1980).

"Depending of the individual's coping abilities, a stimulus is perceived either as challenge to control with the flight-fight defense, *or* as an inducement to conservation-withdrawal (a helpless response) with depression" (Henry, 1980, p. 2). Once the fight or flight response is set in motion, it is best to use some aerobic physical activity such as jogging, swimming, or riding a bike, which will accelerate the dissipation of the stress products that are flowing through the body in order to prevent damage to the body organs.

Martial arts and yoga exercises are included in many Eastern approaches to wellness. These forms of exercise are said to tone muscles, help overcome fatigue and stress, and generally strengthen the body. Many books have been written to introduce the Westerner to the use of these techniques (Carr, 1973; Dunne, 1966; Hittleman, 1973; Maisel, 1963).

Case Study

Checking the Fundamentals

The authors feel that three areas need to be explored with Robert and with every client in order to provide effective treatment. Those three areas involve: (1) checking to make sure the client is not in crisis; (2) determining if there is child abuse or neglect; and (3) doing an assessment for chemical dependency or substance abuse. If any of these are present, they need to be dealt with first.

1. *Is he in crisis?* We feel that Robert is not in crisis because of the following: no suicide thoughts or plan; no obvious signs of depression (for example, no sleep disturbances, no eating problems, no digestive disturbances, or lethargy); he is holding down a job; and he seems energetic without being hyper.

The helping professional can look for psychological signs of stress, using what Witkin-Lanoil (1984; 1986) called the six D's as a checklist. They are: defensiveness; depression; disorganization (or confusion); defiance; dependency; and decision-making difficulties. If any one of those is evident, appropriate action can be taken.

2. *Is there child neglect or abuse?* Because of the home life Robert had during his formative years, it would be valuable to explore this area with him. We recommend that readers refer to the chapter in this book on this area. He currently has a safe place to live and his daily material needs are being met.

3. *Assessment for chemical dependency or substance abuse.* Most schools or counseling centers have excellent tools for this. We recommend that this be done with Robert. In addition, a physical exam might be warranted as well as an exploration of eating, sleep, and exercise habits. Multimodal behavior therapy has some excellent assessment tools to evaluate the balance in a person's life in terms of drugs, diet, recreation, and physical activity.

Additional Interventions

Some other key areas to explore with Robert in terms of stress management are: career/vocational assessment; developing positive peer support; challenging irrational thinking; modeling and role playing; and goal setting, time management, and budgeting.

4. *Career/vocational assessment.* What life skills does he possess and needs to develop in order to become successful? What career information systems would be helpful? Would short-term training be help-

ful? Robert has a strong interest in working with animals and is currently in a work-study program that allows him to do that. He has a limited interest or motivation in continuing with school, and in addition, is somewhat hampered by limited funds. Therefore, short-term training and education would probably be the best for him.

5. *Developing positive peer support*. Robert is sociable, comfortable around others, and a natural leader. We think he would be a good candidate for a peer support group. This would probably enhance his self-esteem and confidence, and could serve as a safety net for him by providing a network of resource people.

6. *Challenging irrational thinking*. Robert would benefit by using RET and SIT to work through some of his faulty and irrational thinking about gangs. Providing accurate information about gangs might help to diffuse some of the glamour and give Robert a more realistic picture of the danger of gang life.

7. *Modeling and role playing*. Robert would benefit from positive modeling and role playing (especially of Black youth and adults) to develop some new behaviors. Such modeling and role-playing could take place in the Independent Living Program (ILP). The ILP was created to help youth who are living in foster care or are on the street to become independent. Many of the teens and staff members are from the Black community and could provide positive role models for him. They also could encourage him to become more involved in the community and give him opportunities to develop his leadership potential.

8. *Goal setting, time management, and budgeting*. Robert has expressed concern and interest in these areas, so they would probably be helpful for him. These interventions can also be generalized to other areas of his life. The counselor might ask Robert to commit to counseling sessions for a certain length of time. The counselor would act as a facilitator to ensure that the goals are reasonable and achievable.

Recommendations and Implications

In this chapter several areas about stress were explored. The first two sections included a case study, a statement of the problem, the stress response mechanism, and the effects of stress. In the review of the literature, three types of stressors were explored: relationship, biological/developmental, and individual. The fourth section presented applications and interventions in terms of support systems and healthy coping mechanisms. The fifth section further explored the case study in terms of checking the fundamentals and presenting additional interven-

tions that the authors felt would be of value to apply to Robert. This final area deals with recommendations and implications.

From the foregoing evidence, it seems clear that there are several key elements in effective stress management, and that one would benefit from taking a holistic view in tackling this complex challenge. We recommend the following: implementing peer support programs such as "Natural Helper"; establishing counseling centers; establishing a crisis center with 24-hour phone lines; having adequate assessment tools; offering local workshops to those in the helping professions to keep them current on crucial data and interventions; and making information available through various means.

Finally, the severity of stress depends, to a large degree, on the predictability of the situation, the person's belief in his or her potential for control, the individual's evaluation of the situation, his or her feeling of competence, and the presence of social supports. Stress-resistant individuals tend to be committed to their work and social relationships, feel in control of life events, view change as a challenge, and recognize the need to balance work and play (Abel, 1974; Ivancevich & Matteson, 1980; Youngs, 1985).

The evidence is clear that stress is costly and has strong effects in subjective, behavioral, cognitive, and biological areas. We cannot afford, either as individuals or as a society, to be ignorant of the toll excessive stress can take on the lives of our young people. Although they need a certain amount of stress and tension to be fulfilled and challenged, it is the task of parents, teachers, counselors, and others in the helping professions to help prepare youngsters—both physically and mentally—to prevent and withstand excessive amounts of stress. Helping professionals need to develop ways of assessing stress in youngsters, identifying which youngsters are at risk, and then designing appropriate programs to help them successfully meet the challenges of life.

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